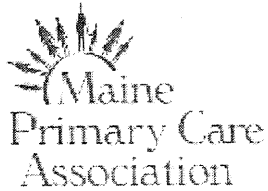


**Joint Select Committee on Health Care Reform  
Opportunities and Implementation**

**Health Insurance Exchanges  
Written Comments Submitted by Stakeholders  
September 21, 2010**



Kevin A. Lewis, *CEO*  
Rev. Robert Carlson, *President*

September 21, 2010

TO: Joint Select Committee on Health Care Reform Opportunities and Implementation  
FROM: Kevin Lewis, CEO  
Maine Primary Care Association  
RE: Comments on Policy Issues and Questions Concerning the Development of an American Health Benefit Exchange Serving the Needs of Maine

Thank you for this opportunity to comment on the development of an exchange operating in Maine and some policy considerations for the formation of such an exchange as described in the Affordable Care Act (ACA). For each set of questions, I have provided some comments and considerations. Much of this material is drawn from an excellent review of exchanges by Timothy Jost and produced by the Commonwealth Fund called Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues (July 2010).

1. Should Maine operate its own exchange or opt to let federal government administer? What are the benefits of operating the exchange? Are there any disadvantages?

The benefits of a Maine-based exchange include the important role the exchange will have in serving as a gateway to other public programs. The Maine exchange must coordinate seamlessly with other public programs to facilitate coverage as people move back and forth between the Exchange and MaineCare (including CHIP). The Exchange should also create continuity of coverage for employees who change jobs.

Additionally, the Maine-based exchange could perform a number of administrative functions on behalf of all the plans operating within the exchange: "processing applications, billing enrollees, conducting financial reconciliation, paying commissions, developing and maintaining Websites, performing marketing and outreach, and providing broker and human resources training." (Jost, p. 17) In this capacity, the Exchange should be designed to reduce the total amount of administrative costs or overhead of insurance coverage in the state.

2. How should an exchange be organized or governed? Should there be a separate exchange for individuals and one for small businesses? Should Maine consider forming an exchange with another state or states? Should the exchange be housed in a government agency, a nonprofit organization or another entity?

The ACA offers opportunities for expanding risk pools, which Maine should pursue in its design of the Exchange. This will necessitate – among other things – a compromise set of state benefit requirements which would apply to both the exchange as well as plans operating outside the exchange. Additional operational considerations of insurance regulation in the context of an Exchange include the following recommended policies:

- Prohibition on insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange;
- Prohibition on insurers from selling only bronze or catastrophic coverage outside the exchange;
- Requirement that plans sell interstate policies only through the exchange; and
- Prohibition on brokers from collecting higher commissions for plans sold outside the exchange, thereby discouraging them from steering business elsewhere.

In addition to these approaches to prevent the lopsided accrual of risk to the Exchange, there are opportunities to build up the risk pool in advance of 2017 when states can bring in the large group market to the Exchange. One such approach is to provide state and local government employee coverage through the exchanges, as this could dramatically expand the size of the participant pool. “Even prior to 2017, states could establish state and local government exchanges that parallel the ACA exchanges and contract with the same insurers. This would immediately increase market share, and after 2017 the two types of exchanges could be merged.” Combining the exchanges for individuals and small business also may be necessary to create a large enough market to attract insurers and to reduce the administrative-cost load.

In addition to efforts to safeguard a level playing field as well as promote a sufficiently large risk pool, policies guiding Exchange formation should provide the greatest amount of consumer choice possible. This would include allowances for plans to cover only local or regional areas rather than the entire exchange. “In most states it will make sense to allow HMOs to participate in exchanges that cover only local or regional areas rather than the entire exchange, as this allows for the maximization of enrollee choices and competition. Care may need to be taken, however, to avoid the redlining of areas with lower-income enrollees or racial minorities.”

3. What rating rules should be in place for carriers offering individual and small group plans in an exchange? Should the same rules apply to plans offered within an exchange and outside an exchange? Should the same rating rules apply to individual and small group plans within an exchange?

Whether to pool the individual market and small group market depends on whether Maine will expand the definition of small group, and the impact of the coverage mandate on the individual market. As explained in the State Health Plan, when Maine looked at this issue in the past, it was determined that while advantageous to the individual market, the combining of markets was detrimental to the small group market. However, with these other changes, the combination of both markets may provide a lower price for both as well as yield a larger total pool which is further effective for mitigating risk and leveraging price. Nevertheless, “because individual mandate penalties do not fully phase in until 2017, unhealthy individuals may be overrepresented in the exchanges for the first few years.” [Jost, p. 6] The ACA’s remedy for this market disequilibrium is a transitional reinsurance program followed by an assessment of plans and insurers with low-risk enrollees and accompanying payments to those with high-risk enrollees.

4. What are the risks of adverse selection within an exchange? How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums? Are there different considerations relating to adverse selection for individual or small group plans?

As Jost points out in his report, “The single most important reason why some exchanges have not succeeded in the past is that they became the victims of adverse selection – they were unable to capture a large enough share of the healthy participants in the insurance market.” (p. 3) In this way, the exchange would turn into a high-risk pool with all of the problems and dynamics that

lead to a death spiral and demand for heavy government support to cover its liabilities. To avoid this problem, policies should be considered for the Exchange and plans operating within the exchange and outside of it that prevent the siphoning off of the healthiest covered lives.

5. The federal law requires a minimum of 5 plans to be offered through an exchange: plans offering 4 benefit levels or tiers – bronze, silver, gold and platinum – and a catastrophic plan for those under age 30 who lack access to affordable plans. How many health plans or types of health plans should be available in an exchange and what policy considerations should guide this decision? Should an exchange have a role in standardizing plans and defining benefits and cost sharing?

The policies of the exchange should set the terms and conditions for participation that provide a guarantee of a level playing field with plans offered outside of the exchange. The market would then dictate the number of plans being offered. The ACA already defines the upper bounds on cost sharing.

6. Should the exchange have a role in selecting carriers to participate in an exchange? What criteria for participation should be included? How many carriers should participate? Or should all carriers be required to participate in an exchange?

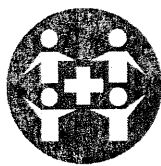
The exchange serving Maine should use its certification authority to promote exchange participation among high-value plans. A proliferation of plan offerings that have little value may serve to harm the public. If there was such a thing as perfect information shared by all buyers of insurance on the exchange, then there would be no risk to promoting a proliferation of participating plans. However, where there is no such thing as perfect information in health insurance, and marketing campaigns can mislead a target audience, individuals could be harmed through the purchase of coverage that doesn't fit their needs and doesn't offer the value necessary to adequately cover their needs. At the same time, the considerations mentioned above necessitate policies that avoid the siphoning of the healthiest lives to plans offered outside of the exchange, promote the creation of the largest risk pooling possible to bring down the costs of coverage, and maximize the greatest availability of choice within the parameters necessary to safeguard a vibrant and sustainable Exchange.

7. How should an exchange be designed to be user-friendly to both individuals and small businesses? Should a website be the primary entry point to an exchange? How can an exchange be designed to provide access for individuals to other publicly funded health plans? What other types of outreach and education are needed? What is the role of the Navigator program? What is the role of insurance agents?

Exchanges will only work for small employers and individuals "if they offer convenience rather than administrative complexity." The Exchange should rely upon the existing network of outreach and benefits specialists among Maine's community health centers (Federally Qualified Health Centers) and other access points to help ease the transition between the Exchange and MaineCare and among the plans offered within the Exchange. Insurance brokers will continue to have an essential role in bringing Exchange offerings to small employers and vice versa. Implementing policies to mitigate the risk of brokers steering purchasers to plans outside the Exchange will be essential to a sustainable Exchange. Lastly, the Exchange should foster the development of a Consumer Operated and Oriented Plan that will allow small businesses and individuals to take on a bigger role in shaping a plan offering and aligning benefits with financial incentives so as to induce behavior change and lead to improved health outcomes.







# Consumers for AFFORDABLE Health Care

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Testimony of Joseph P. Ditré, Esq., Executive Director,

Consumers for Affordable Health Care

September 21, 2010

Good afternoon Chairman Brannigan, Chairwoman Treat and members of the Joint Select Committee. My name is Joe Ditré and I serve as the Executive Director of Consumers for Affordable Health Care, an independent non-profit, non-partisan organization that provides consumers with a voice in their health care system. Thank you for this opportunity to speak on behalf of Maine consumers regarding the creation of Exchanges.

Time is limited, so I would like to focus on high level principles today. Answers to your questions will be provided for more detail.

At its core, the Health Insurance Exchange is a conveniently located marketplace. After all, it is located in your home -- either on your computer or by telephone. It is a marketplace for consumers to purchase health insurance. This is true regardless of the various sources of funds for the premiums.

Here are several of the principles that the Exchange should achieve:

1) **Simplicity.** It should make buying health insurance as easy as possible for the consumer. Think about how complex buying insurance is today - the dizzying array of choices that make it impossible to compare apples-to-apples. When designing the Exchange, keep the consumer, for example, your mother or father or yourself in mind, and ask if she or he or you would be able to understand what is covered and what it not covered, how much it costs, what additional costs there are, and what is the quality of the service.

2) **Uniformity.** When engaged in a transaction as complex as buying health insurance, consistency is important. Therefore, the same products should be sold inside and outside the Exchange, the same rates should be charged, and the same quality information offered. Doing so will prevent adverse selection and level the playing field in the market. While federal rules give the Exchanges the power to decide what is offered in the Exchange, Maine should use its regulatory authority to apply the same rules outside the Exchange.

3) **Affordable Choices.** What good is offering coverage if not everyone can afford it? When thinking about how to define the Bronze, Silver, Gold and Platinum plans, the Exchange will have the option of defining specific benefit levels such as deductible and copay, or simply basing the plan level on actuarial value which is a fancy way of saying the amount of total costs paid by the plan. Plans should be defined based on specific benefit design to enable consumers to make apples to apples comparisons between plans offered by different carriers. A carrier's success would then be determined by the quality of care and service provided, not by the ability to attract lower risk plan participants.

In designing the Exchange, we need to keep our eyes on the end result of all this work. We are here to talk about Exchanges because they will help tens of thousands of Maine residents get access to quality affordable health care.

I would suggest that it will be useful to take the lens of the impact the Exchanges will have on consumers as a way to help answer some of the questions regarding how they might be structured.

An Exchange will have both “back office” and “front-office” functions. The “back office” will include software that helps determine eligibility, subsidies and handles plan enrollment. This might be the same software used by other states, it might also be the same software used by both the individual and small group markets within Maine. Regardless of the number of software programs used, it is still one Exchange. The Exchange will also have front-office functions. These functions will include a website that consumers can see themselves, a Toll-Free telephone call-in service center for consumers to call, and navigators to assist consumers. Regardless of the number of functions performed, it is still one Exchange.

So questions of what is included in a single Exchange – issues around multiple state Exchanges and separate Exchanges for individuals and small employers should be looked at distinctly from what tools are used – back-end operations, front-office websites, and so forth.

This view has implications for how an Exchange should be structured. Those implications include:

- Maine should operate its own Exchange so that it remains responsive to local consumer needs and preferences. Our small population size, relatively small insurance market, movement in the job market, and movement within income brackets does not support operating more than one exchange.
- The governing board of the Exchange should include consumers and policymakers but should not include insurers or providers since they will be financially impacted by the decisions of the board. Doing so will avoid potential conflicts of interest
- Again, we strongly encourage the plans to be defined based on specific benefit design to enable consumers to make apples to apples comparisons between plans offered by different carriers. A carrier's success would then be determined by the quality of care and service provided, not by the ability to attract lower risk plan participants.
- And finally, in order to both avoid adverse selection and present consumers with as many choices as possible, the same plans should be offered both in and out of the Exchange and they should present the same quality information and charge the same rates. Federal rules grant the Exchanges power to decide what is offered within the Exchange. Maine should use its insurance regulatory authority to apply the same rules outside the Exchange

Again, thank you for the invitation to present. CAHC will provide detailed answers to your questions later today.



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**Joint Select Committee on Health Care Reform**

**Health Insurance Exchanges – Consumer Panel**

**September 21, 2010**

Senator Brannigan, Representative Treat and distinguished members of the Joint Select Committee on Health Care Reform Opportunities and Implementation, my name is Robyn Merrill and I am an attorney and policy analyst with Maine Equal Justice Partners, a nonprofit legal aid provider representing the interests of individuals below 200% of poverty in the courts, before administrative agencies and in the Legislature. Maine Equal Justice Partners focuses its legal services on safety net programs that assist individuals and families struggling to make ends meet, such as access to adequate health care, food and income supports, and education and training opportunities.

Thank you for this opportunity to address the committee with our thoughts regarding key policy issues facing policymakers with respect to Health Insurance Exchanges. In light of our agency's area of expertise we would like to use our time today to focus on the Exchange as it applies to individuals and families between 133% and 200% of the Federal Poverty Level. For an individual these percentages translate into an annual dollar amount ranging between \$14,512 and \$21,660 and for a family of four between \$29,547 and \$44,100.

Although the key policy questions provided to guide today's discussion do not address issues of affordability or the option of a Basic Health Plan within an Exchange, we view these as important issues that should be raised as a part of this discussion. Our intent is to raise these policy issues, but not to get into the specifics, as we understand that Judy Solomon, a national expert on health policy from the Center on Budget and Policy

Priorities, will be providing more detail and answering questions about the Basic Health Plan when she presents for this Committee on October 1st.

### **Affordability**

Although the Affordable Care Act includes substantive provisions that make health care more affordable to the millions of Americans with low incomes who simply can't afford to purchase health insurance through their employers or in the non-group market, it doesn't go far enough. A multi-state study found that when premiums for public health programs rose to 3% of a family's income participation dropped by half among eligible individuals and families with low income.<sup>1</sup> Furthermore, additional research highlights that imposing even modest cost-sharing on people with low income results in people foregoing necessary medical care.<sup>2</sup> In light of this research, the required premium contribution of people between 133% and 200% of FPL – between 3 and 6.3% of annual income – and cost-sharing, such as co-payments, is cause for concern. Although participation will be required, we need to seriously consider whether this segment of the population will have access to the right treatment at the right time for the right price. And if not, what that means for the future of Maine people and Maine's workforce.

### **Potential for Administrative Burden**

Aside from the affordability question, is the administrative burden for states to administer subsidies, particularly for lower-income households where incomes fluctuate more than in other higher income ranges. The ACA provides for premium tax credits and cost sharing subsidies that are based on income and paid in advance. If an individual or family earns more or less in some months than in others because of reduced or increased hours, then the Exchange will have to reconcile the advanced subsidy – people may be eligible for a lower or higher subsidy depending on their circumstance. The administrative costs of changing coverage with fluctuations in income for each person between 133% and 200% of FPL would be high. Moving people between plans and dealing with extensive reporting would likely be time consuming and burdensome.

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<sup>1</sup> Leighton Ku and Teresa Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, Winter 1999/2000.

<sup>2</sup> Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.

### **Basic Health Plan**

There are several reasons that a Basic Health Plan option for individuals and families with low income could benefit Maine. First, the Basic Health Plan eases the administrative burden because a reconciliation process would no longer be required. Second, the Basic Health Plan would allow for continuity of care for individuals transitioning between Medicaid and the Exchange because the transition would be seamless for these individuals if the plan is properly designed. Third, the Basic Health Plan would enable families where the parents are covered through the Exchange and the children are still receiving coverage under Medicaid/CHIP to essentially stay within the same plan with the same providers. Moreover, in addition to the above, the Basic Health Plan is economically feasible for Maine because the federal government provides the state with federal funds toward the operation of the program equal to 95% of the premium tax credits and cost-sharing that would have been provided to enrolled individuals if they had been in the Exchange.<sup>3</sup> For all of these reasons, policy makers should consider the Basic Health Plan option as it contemplates the structure of an Exchange in Maine.

We look forward to learning more about the Basic Health Plan option and what it would mean for Maine from Judy Solomon when she testifies before this Committee on October 1st. Thank you.

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<sup>3</sup> Patient Protection and Affordable Care Act sec. 1331(d)(3)(A)(i), as amended by Affordable Care Act sec. 10104(o)





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Tuesday, September 21, 2010

### Comments to the Joint Select Committee on Exchanges

On behalf of the over 32,000 members of the Maine People's Alliance, I would like to thank the Joint Select Committee for this opportunity to provide comments about what Maine should consider while planning the implementation of a health care exchange. The implementation of an exchange is a great opportunity for Maine to make quality, affordable health care more accessible for consumers. It is important that we prioritize the perspectives of consumers as the exchange is designed, and that we include consumers in the planning process.

The exchange is an opportunity to make purchasing insurance an easier process by providing a way for consumers to really compare plans. Perhaps most importantly, the exchange will also be a mechanism for reducing costs and improving healthcare quality. Maine should not pass up the opportunity to run an exchange in our state; it is a chance to continue in the tradition of Maine serving as a national leader in the arena of health insurance coverage and consumer protection. The exchange should be given clear authority to set rules, recommend legislation, and negotiate on behalf of enrollees, but should be ultimately accountable to the public, most likely through gubernatorial and/or legislative appointment of its leadership. Operating our own exchange would mean that the exchange would be accountable to Maine consumers, which would be far more difficult in a federal exchange. In order to provide for maximum accountability to the people it is intended to serve, it is best for the exchange to be run by a government agency.

The exchange should be an active purchaser of insurance, and should aggressively negotiate with any plan permitted to enter the exchange. In order to ensure that all people in Maine are able to access

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coverage, the exchange should be the sole market for most insurance, but a limited number of products should be allowed to be sold both inside and outside of the exchange.

It is important that the exchange is designed to be as user friendly as possible. A website seems like the easiest point of entry, with help through a toll free number and live navigators for those who cannot access the site. The mechanisms for reducing costs and improving quality should be apparent on the website, and the coverage transitions (off and on to public programs like Medicare/Maine Care, between employers, and from the group markets to the individual market) should be as seamless as possible and result in no gaps in coverage.

Maine must also be sure to keep all kinds of consumers in mind when designing the exchange. Although it is extremely important that an easy-to-use website is designed, there are many consumers in Maine, including those without computers, and those who are not proficient in English, who will need further assistance. There must be a toll-free hotline to help answer questions, with an available translation service, and a system of “navigators,” who are licensed and regulated, to assist consumers through the exchange. Setting up the system in this way will help not just individual consumers, but also small business owners whose busy schedule will demand having a live person available to help them navigate the system.

The exchange should be operated for the benefit of individuals, businesses and their employees, not insurance companies and providers. This charge should be included in the exchange’s legislative mandate and mission.

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## **Health Insurance Exchange Making Sure Consumer Needs are Met**

**What kind of information is most helpful to people as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)?**

- Consumers, as individuals or members of small business groups, will want to know the cost of the health coverage alternatives (monthly premiums, deductibles, co-payments), the benefits that are offered, covered hospital and provider networks, and the subsidy that is available to help them pay for needed health insurance. It is important that consumers are able to easily compare options to a clear standard and receive help through hot-lines and community-based “navigators.” We’ve learned from Massachusetts that even what seemed to be a limited set of plan options appeared overwhelming to many enrollees.
- The public will need to be made aware of the Exchange and what it is offering and this will require a major communications and marketing campaign. Based on experience in states that have undertaken health reform, devoting resources to marketing the Exchange and its products, outreach and marketing must be viewed as a key operational element rather than an afterthought.
- AARP recommends that consumers (individuals, small businesses, and employees) be a part of the Exchange’s design and governance to help assure that all planning and decision-making takes into account the consumer’s experience and perspectives. With thoughtful design and strong implementation, an Exchange can simplify an individual’s experience signing up for coverage and improve patient care.

**What kinds of design features can help consumers obtain coverage through the Exchange?**

- From a consumer’s perspective, the Exchange can and should be designed in a manner that will assure consistency and stability in health coverage,

however a family's situation may change. It should help end the trauma of lost health coverage with changing family circumstances (new or lost job, income up or down, divorce, move geographically, children, etc.): where to go to get coverage, how much it will cost, what services will be covered, where to go for services. The Exchange should offer a manageable number of meaningful plan options; and put in place systems to allow it to seamlessly "hand off" and receive transitioning consumers – with no gap in family coverage. We emphasize this point because many individuals and families with incomes <400% of the federal poverty level (approximately \$88,000 for a family of four) have incomes and family situations that vary significantly over a year.

- We recognize that HHS is scheduled to establish interoperable standards and protocols for enrollment in federal and state HHS programs by September 2010. This is a welcome development, as it may facilitate enrollment of individuals into other valuable programs. We urge the federal government to think more broadly than HHS programs, however, as state Exchange subsidies will require linkages with health plans, small businesses administrators, individuals, and the IRS. Setting uniform standards at the national level will help states design Exchange approaches that are consistent with federal law, be administratively efficient and secure, easily understood across state boundaries, and will protect consumers from the anxiety of poorly designed system architecture.
- Another design feature is the "no wrong door" for accessing coverage. A potential consumer would enter one door through which they may sign up for Medicaid or Exchange coverage. States will need extensive assistance in simplifying eligibility and re-engineering antiquated enrollment systems for Medicaid and Children's Health Insurance Programs, and integrating these programs with Exchange coverage. It will be impossible to enroll millions of individuals using a cumbersome and intrusive eligibility platform left over from Medicaid's former link to AFDC; furthermore, Medicaid's MMIS technology is outdated and expensive to modify. From a consumer's perspective, Exchanges should not be designed in isolation from efforts to streamline Medicaid, as this harmonization is key to the consumer's experience in accessing affordable and continuous health coverage.

- If the Exchange is to be sustainable over time, it must not only administer tax subsidies but also rein in health care costs overall. AARP believes that the Exchange should use its buying power to negotiate a better health coverage deal for all enrollees and also drive down costs and drive up value in the health care delivery system.

### **What are best practices in implementing consumer protections standards?**

- The new law fundamentally improves the health insurance marketplace by ending insurers' ability to refuse coverage to individuals and begins to orient competition towards cost and quality. As many of these changes will occur at a state level over time, AARP urges HHS to carefully monitor states' progress and take decisive action if the intent of the new law is being violated and consumers are harmed, as a result.
- A wealth of "best practices" has been generated over two decades about effective consumer protections and health coverage. First is consumer choice. If the insurance market is to function better, consumers must have essential information at hand (that is simple, valid, and meaningful) in order to make choices; they must be able to understand the implication of their choices, and be able to differentiate among alternative options.
- AARP recognizes that development of Exchanges cannot be accomplished in isolation from the traditional insurance market. It's essential that policy-makers create a uniform regulatory framework governing the Exchanges and the broader insurance market, to protect against adverse selection, uneven consumer protections, and excessive rate increases.

### **Based on your experience, how do we design and market an exchange to draw in "young invincibles?"**

- Keeping the Exchange affordable by attracting younger and healthier individuals will be key to its success. Appealing to these audiences through media they currently use (like Facebook and other social networking tools) and making sure the insurance addresses the risks they believe they will face will be really important (eg. accidents).
- In addition, we've learned from working with younger adults that resent having to pay for "people who don't take care of themselves." So it's important that the essential benefits package have a strong emphasis on

prevention and wellness benefits that younger adults will find more appealing.

- “Young invincibles” over time can be educated to see the value of seeking health coverage, particularly if coverage and provider options are designed to meet their specific health needs (e.g. reproductive health, substance abuse, etc.). AARP’s interest is assuring the availability of affordable coverage particularly for those older Americans who have been excluded from the conventional market.

**From the consumer perspective, what issues should be considered in terms of selecting or allowing plans to participate in the Exchange?**

- If the promise of national health reform is to be realized, AARP believes that plans approved for participation in the Exchange should meet standards of benefit adequacy (coverage must be meaningful, not bare bones) and established standards of quality (e.g. consumer satisfaction, provider service quality, etc.). The Exchange should be empowered to negotiate the best possible price and service quality from plans bidding for Exchange participation.

**What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency? For older people who may not be internet savvy?**

- There is a wealth of existing knowledge about how public programs can reach diverse audiences, including those with language or literacy limitations or limited internet savvy. It is essential to review this wealth of information that has been gained over years of Medicaid and other program outreach / enrollment, both creative and successful and not.
- Obviously, an internet-based Exchange **must** be supported by well-trained customer service representatives (CSR) who can answer telephone and field questions in real time and in different languages. The federal government should establish minimum standards for CSRs and call centers and adequately fund outreach and enrollment efforts.
- AARP recommends that HHS convene a group of partners across federal agencies and externally to design outreach principles and consider ALL the

intersecting stakeholders and their information needs, not simply consumers (e.g. health plans, tax preparers, employers, providers, Medicaid partners). This will help to assure the generation of consistent and accurate information across many sectors, and assist consideration of the most vulnerable consumers.

**Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (e.g., collecting complaints at the Federal level, versus at the State or Exchange level)?**

- There is a range of nationwide information (e.g. NCQA), state report cards, private sector reporting, managed care reporting, accrediting organizations, and health professional quality measures that should be reviewed to identify options and preferred alternatives. The federal government should design through regulation a realistic set of quality standards that may be augmented by state governments; AARP views consumer complaints as just one quality measure.

**Conclusion:** getting the Exchanges “up and running” in the time frame specified in law will require us collectively to overcome herculean challenges at every step. A commitment to problem-solving and refining approaches along the way is needed. AARP is committed to contributing to that effort and we thank you for this invitation to share our ideas about how consumers needs can be met.

# Policies to Assure a Pro-Consumer Health Exchange

Governance	<p>Consumers &amp; businesses not majority</p> <p>Wasteful spending</p>	<p>Fully transparent</p> <p>Stakeholder &amp; public input</p> <p>Strong relationships with employers</p> <p>Frugal spending</p>
Oversight	<p>Takes prices set by insurers</p> <p>No standards for benefit design, call centers, quality, &amp; costs</p>	<p>Negotiates rates &amp; benefits</p> <p>Sets high &amp; realistic standards that improve value</p>
Usefulness	<p>Exchange is invisible</p> <p>Too many options &amp; few tools for comparison</p> <p>Customer service limited &amp; underfunded</p> <p>Awkward eligibility mechanisms</p>	<p>Robust outreach to consumers/business</p> <p>Manageable number of meaningful choices for consumers</p> <p>Culture of problem solving &amp; quality service</p> <p>Seamless, as personal circumstances change</p>
Integration	<p>Connection across Medicaid, plans, and subsidies is cumbersome/confusing</p> <p>IT system and business processes antiquated</p>	<p>Provides consistency &amp; stability in coverage as individuals' circumstances change</p> <p>Links seamlessly to Medicaid and subsidies</p> <p>IT platform enables communication</p>
Sustainability	<p>Allows outside market to offer products on favorable terms</p> <p>Fails to keep up with market &amp; clinical change</p>	<p>Protects against adverse selection</p> <p>Adjusts to medical breakthroughs of health transactions</p> <p>Cuts waste &amp; raises efficiency</p>
Size	<p>Too small to drive significant value improvements in market or achieve cost savings</p>	<p>Large enough to enable quality improvements &amp; cut costs</p> <p>Large enough to assure risk pool stability &amp; economies of scale</p>

# MAINE ASSOCIATION OF HEALTH PLANS

To: Members of the Joint Select Committee on Health Reform

From: Katherine Pelletreau, Maine Association of Health Plans

Date: September 20th, 2010

Re: Preliminary Comments on Health Insurance Exchanges

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On behalf of the Board of Directors of the Maine Association of Health Plans (MEAHP), I am pleased to offer the following comments on exchanges. MEAHP is a statewide trade association representing insurers doing business in Maine. Our current membership includes Aetna, Inc., Anthem Blue Cross and Blue Shield of Maine, CIGNA HealthCare of Maine Inc., Harvard Pilgrim Health Care, and UnitedHealth Group. MEAHP offers these comments as a response to the questions posed by the Committee. Individual member plans may also choose to submit their own comments. We consider these our initial but not necessarily our final public comments on exchanges. We would note there is a federal Request for Comments on exchanges pending that requires submission of comments by October 4<sup>th</sup>, 2010. Many of our Plans and our national trade association, America's Health Insurance Plans, are intensely engaged in efforts to develop their thinking around exchanges to meet that deadline and as additional information becomes available.

Although federal health reform outlines the core functions of an exchange, much discretion is given to the states to define the specifics of the structure and build an effective, consumer based approach that encourages competition and broad participation.

We believe there are four fundamental principles critical to the development of an effective Exchange:

- Exchanges should supplement but not replace existing markets and regulatory functions should not be duplicated.
- Exchanges should offer consistent and objective participation criteria to allow for meaningful choices to consumers both within and outside the exchange.
- Mechanisms should be established that ensure increased participation and mitigate risk selection both inside and outside of the exchange market.
- Uniform standards around which data elements are used should be established to ensure that consumers have access to useful, accurate and understandable information.

We have endeavored below to respond to each set of questions you have raised.

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**1. Should Maine operate its own exchange or opt to let the federal government administer? What are the benefits of operating the exchange? Are there any disadvantages?**

We support the establishment of a state run health exchange with an on-line marketplace. We believe this approach offers the greatest benefit to Maine consumers and allows for local responses to questions and issues as they arise. It also provides greater flexibility for our state and the ability to respond to the unique features of our marketplace.

**2. How should an exchange be organized and governed? Should there be a separate exchange for individuals and one for small businesses? Should Maine consider forming an exchange with another state or states? Should the exchange be housed in a government agency, a nonprofit organization or another entity?**

The health plans support a facilitative exchange, not an additional regulator. Governance must be broad based with representation from the relevant stakeholders including carriers. Governance must represent a strong partnership approach between those offering products through the exchange, those purchasing through the exchange and those regulating the marketplace. The purpose of the exchange should be to promote a competitive marketplace with open access. An exchange should not duplicate functions currently undertaken by health plans, the Bureau of Insurance or other entities. It is important to recall that all administrative expenses incurred by the exchange will ultimately be borne by consumers.

In weighing whether or not Maine will establish separate exchanges for the individual and small group markets, we suggest that several factors be considered including: separate management of risk pools, separate products, and administrative complexity. In any scenario, carriers should be able to choose which markets they participate in – inside and outside of the exchange.

The development of an exchange will be new for Maine and limiting the complexity, especially initially, will be important. For small groups, we support a phased in approach over time with an initial focus on those groups with 50 or fewer employees and then expanding access in concert with the expansion of the definition of small group under federal law through 2016.

In Maine's case, we do not support a multi state exchange because it would require uniformity among the participating state's laws and regulations that does not currently exist. There has been some mention of collaboration "behind the scenes" on administrative matters such as information technology and this may be a reasonable way to share the costs, so long as the individual and small group markets remain separate and distinct.

The funding of the exchange should be spread as broadly as possible for sustainability and the governing body must have fiduciary responsibility to the State. Care should be taken to ensure that one market does not subsidize another.

**3. What rating rules should be in place for carriers offering individual and small group plans in an exchange? Should the same rules apply to plans offered within an exchange and outside an exchange? Should the same rating rules apply to individual and small group plans within an exchange?**

We favor similar rules inside and outside the exchange to minimize adverse selection issues. The Bureau of Insurance should continue their current role in oversight of rates, as they are responsible for ensuring that health plans remain solvent. The exchange should not set or negotiate premiums but should enable consumers to compare costs and benefit designs across

plans. The exchange should have no say over what rates are. To increase affordability, we support the expansion of rating bands to bring Maine into consistency with the federal guidelines of 3:1.

For several years we have resisted the notion that the individual and small group markets be merged in Maine. The Blue Ribbon Commission on Dirigo and the Insurance and Financial Services Committee carefully considered merging the markets and concluded that this was not the right approach for Maine. In 2007, Gorman Actuarial conducted a study that explored the possibility of merging the markets that found that costs for small businesses would increase. (Reform Options for Maine's Individual Market: An Analysis Prepared for the Bureau of Insurance, May 30, 2007, pg. 18).

**4. What are the risks of adverse selection within an exchange? How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums? Are there different considerations relating to adverse selection for individual or small group plans?**

Adverse selection is a concern in any significant insurance reform effort. To guard against it, the exchange must adopt policies that prevent people from moving in and out of the market, as they need coverage. For operational simplicity and to avoid substantial increases in administrative costs, we support limited open enrollment periods and conforming the rating bands with the bands established in federal law. We remain concerned that federal law may not be stringent enough to prevent adverse selection and do not support individual's being able to opt-out of available employer coverage except to the extent permitted by federal law.

**5. The federal law requires a minimum of 5 plans to be offered through an exchange: plans offering 4 benefit levels or tiers---bronze, silver, gold and platinum---and a catastrophic plan for those under age 30 or who lack access to affordable plans. How many health plans or types of health plans should be available in an exchange and what policy considerations should guide this decision? Should an exchange have a role in standardizing plans and defining benefits and cost sharing?**

It is our understanding that federal law requires that only gold and silver plans be offered through an exchange by a carrier. We do not believe the exchange should design benefits or adopt benefit requirements beyond those required under federal law. The Maine Bureau of Insurance already effectively regulates benefits and cost sharing. A level playing field should be maintained by requiring that health benefit plans offered inside and outside the exchange meet the same market standards such as coverage of mandated benefits, premium taxes and assessments such as the Dirigo assessment, utilization review requirements, rating rules, etc... While carriers offering a product inside the exchange should be allowed to offer the same product outside of the exchange, carriers must also be allowed to offer other plans that meet applicable federal requirements.

**6. Should the exchange have a role in selecting carriers to participate in an exchange? What criteria for participation should be included? How many carriers should participate? Or should all carriers be required to participate in an exchange?**

Carriers should not be required to participate in the exchange. Nor should the exchange function in a way that discourages carriers from participating. It is in the best interest of the exchange and the market, to maximize participation in the exchange. There should be no limitation on the number of plans that can participate - the exchange should be open to any licensed carrier who meets the requirements.

**7. How should an exchange be designed to be user-friendly to both individuals and small businesses? Should a website be the primary entry point to an exchange? How can an exchange be designed to provide access for individuals to other publicly funded health plans? What other types of outreach and education are needed? What is the role of the Navigator program? What is the role of insurance agents?**

We support the use of a web-based portal to access the exchange. It seems the most effective way to present complex materials to a broad audience. The web portal should function in conjunction with local access to education and assistance.

The exchange should have limited enrollment functions in the commercial market. For example, applications for enrollment should be accepted by the exchange and forwarded to the health plans. Consumers will be best served if they are served by their health plan for enrollment and subsequent activities such as requesting an ID card, demographic updates, checking claims, renewals, customer service, etc. Carriers already have the administrative systems in place to handle this.

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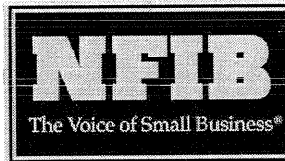
STATE OF MAINE

ONE HUNDRED AND TWENTY-FOURTH LEGISLATURE

JOINT SELECT COMMITTEE ON HEALTH CARE REFORM  
OPPORTUNITIES AND IMPLEMENTATION

**Health Insurance Exchanges: Key Policy Issues and Questions**

By January 1, 2014, the federal Affordable Care Act (ACA) requires each state to have an exchange to facilitate the purchase of health insurance by individuals and small employers. Under the law, a state may choose to operate its own exchange in compliance with federal law or let the federal government operate and oversee the exchange in their state. To assist the Joint Select Committee on Health Care Reform, we are soliciting comments on the questions below. You are invited to respond to any of the questions below in writing. These questions should also form the basis of your oral comments provided to the Joint Select Committee at their invitation on September 21.



Initial responses of NFIB Maine to questions posed below.

David R. Clough, State Director – Maine

In consultation with Dr. Bob Graboyes (MSHA, PhD), NFIB Senior Healthcare Advisor  
[www.nfib.com/DrBob](http://www.nfib.com/DrBob)    [www.nfib.com/HealthReform](http://www.nfib.com/HealthReform)

1. Should Maine operate its own exchange or opt to let federal government administer?
  - a. What are the benefits of operating the exchange?
  - b. Are there any disadvantages?

**NFIB – Impression is that the state should do it. Gives them some control over the functioning. Otherwise, dependent on and vulnerable to DC.**

2. How should an exchange be organized and governed?
  - a. Should there be a separate exchange for individuals and one for small businesses?
  - b. Should Maine consider forming an exchange with another state or states?

- c. Should the exchange be housed in a government agency, a nonprofit organization or another entity?

**NFIB – How organized and governed? Who knows? Utah looks like the best model, but we're in unknown territory.**

**Separate vs. merged markets? NFIB has discussed this but not yet adequately resolved its preferences. However, a May 2007 report ("Reform Options for Maine's Individual Health Insurance Market") for the Bureau of Insurance indicated a merged market would require an increase in small group average premiums to offset a reduction in individual market premiums. The greatest increase would be in premiums for firms with 10-50 employees.**

**Goal articulated by Maryland Health Care Reform Coordinating Council: "The exchange must be well-designed, with governance rules and a structure that are suited to competition, choice, flexibility, and adaptability as the health insurance market evolves."**

**Benefits of regional exchanges ("Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues", July 2010, The Commonwealth Fund): Give smaller states options of sharing administrative costs, creating larger markets, and having access to bigger insurance pools.**

**For the some of the same reasons that NFIB supported multi-state association health plans, regional exchanges may offer particular cost-saving and choice opportunities for smaller states such as Maine.**

- 3. What rating rules should be in place for carriers offering individual and small group plans in an exchange?
  - a. Should the same rules apply to plans offered within an exchange and outside an exchange?
  - b. Should the same rating rules apply to individual and small group plans within an exchange?

**NFIB – Strongly inclined toward same rules inside and out to minimize adverse selection. Also tend to favor consistent rules for individuals and small businesses for the same reason, but less sure about the mechanics.**

- 4. What are the risks of adverse selection within an exchange?
  - a. How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums?
  - b. Are there different considerations relating to adverse selection for individual or small group plans?

7. How should an exchange be designed to be user-friendly to both individuals and small businesses?

- a. Should a website be the primary entry point to an exchange?
- b. How can an exchange be designed to provide access for individuals to other publicly-funded health plans?
- c. What other types of outreach and education are needed?
- d. What is the role of the Navigator program?
- e. What is the role of insurance agents?

NFIB – The Massachusetts website is probably as good a model as you'll find – since there aren't many out there. However, might want to also check Utah's. Switzerland is known for having a very efficient presentation.

Website point-of-entry facilitates electronic application.

Not sure about matter of access to other publicly-funded health plans (e.g., Dirigo, MaineCare). ACA speaks to issue of Medicaid. Steering people to Dirigo could be seen as an attempt at a backdoor-public option, an effort to migrate people away from the private market.

Agents should have a role.

#### Additional Considerations

- 1. Definition of "Small Group Market"
  - a. Includes employers with 1-100 employees
  - b. Until 1/1/2016 states may elect to define it as employers with 1-50 employees

NFIB – No policy direction at this time on whether to go with 1-100 now or later; however, it is something that should be assessed.
- 2. ACA Effects on Small Firms
  - a. Tax credits may not be as useful as ACA advocates wish
  - b. ACA will have significant effects on small firms; effects not yet well understood
- 3. Cautious Approach
  - a. Numerous states, if not all, are examining their responsibilities and opportunities, including issues relating to exchanges.

NFIB – Maine should take advantage of implementation work being done in other states, to the extent practicable, and be careful to not rush to judgment on public policy choices where the ACA timelines permit a cautiously deliberative process.



## **FIVE UNAFFORDABLE FACTS ABOUT THE NEW HEALTHCARE LAW: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

### **1. The tax credit is *not* a panacea for small businesses**

Often cited as the cure-all for small businesses, the small business tax credit will do little to nothing to make purchasing insurance more affordable for small firms. A tax credit that is poorly structured is not going to provide sustainable and long-term relief from high healthcare costs.

- Very few small businesses will actually qualify for the tax credit, early estimates by CBO cite that just 12 percent of the small business population would benefit in any way.
- The credit is very restrictive and puts small business owners through a series of complicated "tests" to determine the actual amount of the credit. Three conditions must be met for small businesses to qualify for any portion of the credit:
  1. *Business size* – Very few small firms will receive the full credit (only firms with 10 employees or less). For firms with 11-25 employees, the credit is reduced per employee. Firms with more than 25 employees get NO credit.
  2. *Average employee wages* – The credit is tied to the average wage of workers. Only firms who pay their workers \$25,000 or less are eligible for the full credit. The credit is reduced as the average wage goes up, stopping at \$50,000. (Note: Average wage for a firm with 10 or fewer employees is approximately \$27,000.)
  3. *Employer contribution* – Only firms covering 50 percent or more of insurance costs will be eligible.
- The credit is only available for a maximum of six years, but healthcare costs will continue to increase well after those six years.

### **2. A tax on small business health insurance plans**

Messaged as a "health insurance fee," this tax is actually a tax on small business. The new tax is structured as an annual fee on insurers and it does not expire. The annual "fee" begins at \$8 billion in 2014 and steadily increases to \$14.3 billion in 2018. In subsequent years, this fee remains at \$14.3 billion annually added to whatever the rate of premium increase is for that year. One thing health insurers (and the CBO) have made clear: new taxes on them mean new costs passed on to customers. Small businesses will be paying for this new tax.

- *How it works:* An insurer's portion of the annual tax will be determined based on their market share. Insurers aren't simply going to absorb this new, expensive tax.
- These new costs will be passed solely onto the fully-insured market (where nearly all small businesses buy their insurance) because Congress exempted self-insured plans (big business and labor unions are exempt).
- Early estimates from policy analysts show family premiums are expected to go up at least \$500 per year.
- *Simply put:* This is not a tax insurers will be paying. This is a tax on small businesses' health insurance plans.
- Small businesses already suffer from high and volatile costs increases; a new tax like this doesn't help to reduce future costs.

### **3. Increase the tax paperwork costs on small businesses**

The so-called “corporate reporting” requirement will place a new and enormous tax-filing burden on all small business owners. The cost of complying with the new filing requirements will increase the cost of doing business and falls disproportionately on small business owners.

- Businesses will have to send Form 1099s for every business-to-business transaction of \$600 or more – a tremendous new paperwork burden.
- The costs associated with tax paperwork (on average, more than \$74 per hour) is the most expensive paperwork burden that the federal government imposes on small business owners.
- The cost of tax compliance falls heavily on small business and is 66 percent higher for a small business compared to a large business.
- Complying with the tax code is especially burdensome to small business owners, because they lack in-house finance departments like most large businesses. This means the burden to comply with the paperwork is either handled by the owner or outsourced to an accounting firm.

### **4. An unprecedented increase in Medicare payroll tax**

Since its creation, payroll taxes that fund Medicare programs have been dedicated specifically to funding Medicare. Not only does H.R. 3590 increase the Medicare payroll tax to 2.35 percent but it uses the additional revenue to pay for non-Medicare programs, creating a dangerous precedent to use payroll taxes to pay for more non-Medicare programs in the future.

- The bill adds a new tax on income over \$200,000 for individuals (\$250,000 for joint filers). Adding to the problem, wages are not indexed for inflation, meaning that more small businesses will face this tax increase each year.
- Since 75 percent of small business owners pay their taxes at the individual level, this tax will hit the business income of many small business owners.
- The businesses most likely to see the tax increase are those that employ between 20 to 200 workers. These businesses account for more than one-quarter of the American workforce.

### **5. A new Medicare tax on non-payroll income**

This new tax continues the unprecedented trend of dedicating Medicare tax revenue to non-Medicare programs and also expands the tax to additional sources of income.

- Medicare has traditionally been funded by taxes paid on a worker’s wages. The new 3.8 percent tax on those reporting \$200,000 in income (\$250,000 for joint filers) will, for the first time, apply to non-wage income such as capital gains, rents, interest, royalties and dividends. (75 percent of small business owners pay their taxes at the individual level).
- Ninety-five percent of small business owners own real estate. Whether the real estate is sold for a profit or rented to another business, this income will now be subjected to an additional 3.8 percent tax.
- This new tax will deter investment in businesses and other profit-earning ventures.



## **Will the Small Business Tax Credit help small business owners provide insurance?**

PL 111-148, the Patient Protection and Affordable Care Act, includes a small business tax credit, which supporters claim will help small business owners provide health insurance to their employees. But will this credit really help?

### The Proposed Credit

The small business health tax credit included in the Healthcare Reform law provides a 35% tax credit for the employer's healthcare costs. The credit is available from 2010 to 2013 and then a 50% credit is available for two additional years if the employer purchases coverage in the health insurance exchange.

A business with 10 or fewer employees with a per employee compensation level of \$25,000 or less is eligible for the full credit. The credit phases out in two ways:

- The number of employees from 11 to 25 and
- Compensation between over \$25,000 up to \$50,000.

An employer must pay 50% of the cost of the employee's coverage to be eligible for the credit.

### Concerns about the credit's effectiveness

The number one challenge facing small employers that provide health insurance is the rising cost. Small businesses tend to operate on a very thin profit margin, so any increase in the cost of doing business – such as annual, double-digit premium increases – presents a real challenge to small business owners.

The tax credit included in the Healthcare Reform law will help some small businesses. But because of the many conditions attached to the credit its impact is limited, specifically:

- **The availability of the credit is too short.** A credit that is only available for two years inside the exchange means that every small business owner that claims the credit will see a large spike in their out-of-pocket costs for healthcare in year three. While the credit goes away, the healthcare costs do not.
- **The conditions are too restrictive.** Phasing the credit out based on two factors – number of employees and average wages – means that the amount of the credit is reduced faster. In addition, adding conditions like purchasing minimum coverage, paying 50% of the costs, or buying insurance in the exchanges means that fewer businesses will qualify for the credit.

Small business owners support a tax credit to assist in covering the cost of health insurance. Unfortunately, the credit included in the new healthcare law does not provide the kind of long-term benefits that will truly increase affordability for small businesses and their employees.

## 2010 Health Insurance Reform Tax Credit Calculator for Small Business

Does your business qualify for the healthcare law's new small business tax credit on health insurance? If so, how big is your credit?

Instructions: Fill in variables for rows A, B, C, & D and click "update." B cannot be larger than A.

A: Number of full-time employees in firm	14
B: Number of employees participating in insurance plan	12
C: Annual employer premium contribution per participating employee. (Must be at least 50% of total insurance premium to qualify for credit.)	3,000
D: Average annual wage per employee	36,208
E: Total employer premium contribution ( = B x C )	\$36,000
F: Tax credit as % of premium contribution (This shrinks as A and D increase.)	10.27%
G: Total tax credit ( = E x F ) [Note: This credit increases by almost 43% in 2014.]	\$3,696
H: Tax credit per participating employee ( = G / B )	\$308

Update

Reset

**Here's how to begin asking:** The IRS has updated its website to provide information to help small employers understand the new small business healthcare tax credit and determine whether they are eligible for it. The information is at [www.irs.gov](http://www.irs.gov) and includes: (1) a graphic to help employers quickly determine if they qualify for the credit; (2) scenarios that explain how the credit will affect certain businesses; and (3) A set of frequently asked questions and answers. Interested small-business owners are strongly encouraged to contact their accounting professional for specific guidance related to their businesses, employees and particular business situation.

In the meantime, the calculator above will help you estimate your firm's credit. **Just enter four numbers:**

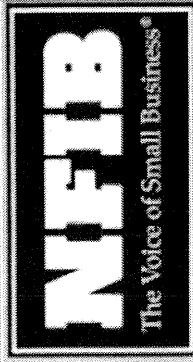
- (A) How many full-time employees your business has.
- (B) How many employees participate in your company plan.
- (C) How much you contribute toward each employee's insurance premium.
- (D) The average wage per employee.

The table will generate four variables (E, F, G, and H) related to your company's insurance costs and premiums. Note: only employers contributing at least 50% of the total premium are eligible for the credit. (Under a recent IRS guidance, businesses that contribute at least 50% on individual policies will be deemed to have met this requirement.)

**WARNING:** This law is brand-new. We (and everyone else) are just beginning to understand the thousands of complex provisions – including some associated with this credit. The calculations here will change if: (1) if the firm uses part-time employees, (2) if the owner and his or her family purchase their insurance separately, (3) if the firm has a mix of individual and family policies in its pool, and (4) if the Secretary of HHS determines that the company plan is more expensive than some "average" plan to be defined later. Also, the credit is neither refundable nor transferable, meaning it can only be used to offset actual tax liabilities.

# The Free Rider Provision: A One-page Primer

Calculating the healthcare law's free rider tax penalties for businesses with one or more employees receiving insurance subsidies. Understanding the free-rider provision's bottom-line effects.



## [1] A business owes a free-rider penalty ONLY if it meets two conditions.

- If it has more than 50 full-time employees or full-time equivalents. Each 120 hours per month of part-time labor counts as a full-time equivalent.
- If one or more of its employees receive premium credits (government subsidies) to help purchase health insurance in the exchange.

## [2] An employee ONLY receives a premium subsidy if he meets two conditions.

- The employee's household income must be less than 400% of the Federal Poverty Level (FPL), which varies with family size. For a family of four, 400% FPL = \$88,200. Household income includes the income of the employee's spouse and of other dependent members of the household.
- The employee's portion of the insurance premium on the employer's plan must exceed 9.5% of the employee's household income.

## [3] If a business DOES owe a free-rider penalty, the calculations are as follows:

- If the business DOESN'T provide health insurance, its annual penalty equals (the total number of employees in the firm (subsidized and unsubsidized) minus 30) x (\$2,000). In the table below, in [S3] and [S4], the 51-employee firm owes \$42,000 = (51-30)x\$2,000.
- If the business DOES provide health insurance, its annual penalties equal THE LESSER OF {the number of subsidized employees} x {\$3,000} OR {the number of employees in the firm (subsidized and unsubsidized) minus 30} x \$2,000. In [S4], it pays \$6,000 (the lesser of \$6,000 and \$42,000). In [S6], it pays \$44,000 (the lesser of \$75,000 and \$44,000).

## [4] Observations from the table

- [S3] vs. [S5]: For a non-providing firm, the free rider provision penalizes the firm \$2,000 for creating an additional job.
- [S3] vs. [S4]: For a non-providing firm, the free rider provision DOES NOT penalize the firm for having more subsidized employees.
- [S3] vs. [S4]: For a providing firm with few subsidized employees, the free-rider provision penalizes the business \$3,000 for each additional subsidized employee.
- [S3] vs. [S5]: For a providing firm with few subsidized employees, the free-rider provision DOES NOT penalize the business for creating an additional job – as long as the new employee is not subsidized.
- [S6], [S7], [S8]: A providing firm with many subsidized employees pays the same penalty as a non-providing firm of the same size.
- [S6] vs. [S7]: For a providing firm with many subsidized employees, the free rider provision penalizes the firm \$2,000 for creating an additional job.
- [S6] vs. [S8]: For a providing firm with many subsidized employees, the free rider provision DOES NOT penalize the firm for having more subsidized employees.
- [S6] vs. [S9]: A firm can reduce its penalties tremendously by replacing full-time employees with part-timers.
- [S1] and [S2]: Unless the business has over 50 full-time employees or FTEs AND has at least one subsidized employee, there are no penalties.

Scenarios	[S1]	[S2]	[S3]	[S4]	[S5]	[S6]	[S7]	[S8]	[S9]
Total employees	50	51	51	51	52	52	53	52	32
# of Unsubsidized employees	49	51	50	49	51	27	28	26	7
# of Subsidized employees	1	0	1	2	1	25	25	26	25
# of Full-time equivalents (part-time hours in one month divided by 120)	0	0	0	0	0	0	0	0	20
Penalty for a business that DOES provide health insurance	\$0	\$0	\$3,000	\$6,000	\$3,000	\$44,000	\$46,000	\$44,000	\$4,000
Penalty for a business that DOES NOT provide health insurance	\$0	\$0	\$42,000	\$42,000	\$44,000	\$44,000	\$46,000	\$44,000	\$4,000



To: The Distinguished Members  
of the Joint Select Committee  
on Health Care Reform  
Opportunities and Implementation.

From: Daniel Bernier representing  
MAHU, NAIFA-ME and MIAA

Date: September 21, 2010

I want to thank you for the opportunity to address the Committee on Exchanges. I provide the following materials and a few key points:

**Materials**

1. Resolution passed by the NAIC on the role of Agents (Producers).
2. Wading through Medical Insurance Pools: A primer by the American Academy of Actuaries. This paper explains the differences between one employer with 3,000 employees and 1,000 employers with 3 employees for rating purposing. It goes over many of the problems you will face in creating an exchange. Please note the impact of employer size on claims. The American Academy of Actuaries is one of the only groups specifically mentioned in statute in Maine and almost every state. They carry that much weight.
3. Hypothetical demonstrating how adverse selection works.
4. Piece from Kiplinger's Tax letter mentioning IRS' limited authority to enforce penalties on people who do not buy insurance.
5. Savings from Health Savings Account Compatible Plans. This is a real quote for my business.
6. Gorman Actuarial Study contracted for by the Maine Bureau of Insurance. A portion of this study deals with merging the individual market and the small group market. However, it assumes you can adjust rates for employer size which you cannot do under the Federal law. The impact on employers would

therefore be worse than this indicates. (My understanding is that the Bureau has already started the process of updating this study).

7. State rating restrictions according to StateHealthFacts.org.

### **Key Points**

1. **The Exchange should not be afraid of competition.** The existing private market should be allowed to function. The exchange and the private market should function under the same rating rules. If the exchange is truly a good idea it should not be afraid of competition on a level playing field. The exchange will have an advantage over the private market due to Federal tax credits.
2. Most small business count on their insurance agent (or producer) to act as their human resources department as the business owner is too busy dealing with other issues. The NAIC recently recognized this important role for the agent (or producer) in the attached resolution.
3. **A major question is who will enforcement actions be brought against if the insurance laws are violated.** Will they be brought against the exchange? Will they be brought against the insurer? Will they be brought against an agent or producer? To the extent the exchange uses licensed agents (Producers) the Bureau of Insurance has enforcement authority. To the extent the exchange uses unlicensed individuals, the Bureau does not currently have enforcement authority.
4. **Another question is whether or not the exchange will have the authority to bind insurance carriers.** To the extent the exchange uses licensed insurance agents who are appointed by companies, the agents have binding authority already.
5. Adverse selection is a problem the Exchange will face. Two ways to protect the exchange from adverse selection are rating flexibility and offering H.S.A. plans.

### **Community Rating**

- Maine 1.5 to 1 (+/- 20%) (Maine also allows rating for employer size in addition to the 1.5 to 1 band).
- Federal Law 3 to 1 (+/- 50%) Federal law does not allow rating for group size.
- Maine is one of a small number of States with a community rating law stricter than 3 to 1.

The elimination of group size as a rating factor is one of several reasons Maine needs to consider broadening its rating restrictions to the Federal 3 to 1. Broader community rating will also help to protect the exchange from adverse selection.

Smaller employers are moving to H.S.A. Plans. If the exchange does not offer at least one H.S.A. plan, it will not be appealing to smaller employers. The really rich benefit plans only appeal to the worst risks. The exchange needs to offer a plan that would be appealing to all risks, otherwise it will have adverse selection problems.

6. The biggest key to a successful exchange will be an experienced board that knows how to run an insurance program.
7. The Agent community would prefer a Maine exchange to a Federal exchange. A Maine exchange would be better able to adjust to unique features of Maine's market. Insurance Agents have a long history of fighting for State Regulations of Insurance rather than Federal Regulations.

## **Resolution**

### *To Protect the Ability of Licensed Insurance Professionals to Continue to Serve the Public*

Sponsored by Illinois, Maine, Florida, Kansas, Oklahoma, Louisiana, Alaska, New Hampshire, Utah, South Carolina, North Carolina, Nevada, Montana, Ohio, New Jersey, Kentucky, Missouri, Michigan, Connecticut, Tennessee, Washington, Delaware, California, New York, and North Dakota

WHEREAS: Licensed health insurance producers (agents and brokers) provide a wide range of services for both individual consumers and the business community. Producers interface with insurers, acquire quotes, analyze plan options, and consult clients through the purchase of health insurance;

WHEREAS: In addition, producers provide guidance regarding benefit and contribution arrangements to ensure compliance with applicable state and federal laws/regulations; assist with establishing Section 125 plans, HRA, FSA, and other programs to maximize tax advantages and ensure compliance with applicable IRS guidelines; create educational materials and provide on-site assistance to aid in employee benefit communication; assist in managing eligibility for new hires and terminated employees; provide advocacy for employees through the health insurance claim process; and advocate for employers with insurers in developing proposals, renewals, and for service issues throughout the year;

WHEREAS: In order to meet these responsibilities, producers are required to complete continuing education on an ongoing basis in order to maintain appropriate licenses. This requirement to maintain educational standards helps assure the insured public that producers remain current with the ever-evolving insurance market;

WHEREAS: It is essential that producers continue to perform these duties, and others, as the Affordable Care Act has made significant changes to the regulatory environment for health plans. To understand these changes, employers and consumers will need professional guidance even more in the future. This service is disproportionately important for small businesses, as producers often fill the role of an HR department as well as professional consultant.

WHEREAS: The Affordable Care Act provides for "Navigators" to conduct public education and distribute fair and impartial information concerning enrollment in health plans and provide referrals for consumer assistance. While these are important activities, Navigators are not licensed and trained insurance producers and are not authorized to engage in all activities that are appropriate for licensed producers. Unless the activities and compensation of Navigators are carefully structured, this program could provide an avenue for untrained individuals to evade producer licensing requirements and expose consumers to harm.

WHEREAS: The core mission of state insurance regulators is to protect consumers in all aspects of the business of insurance, and the continuing role of producers in the health insurance transaction warrants a transitional approach as we move toward January 1, 2014.

***WE, THE MEMBERS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, THEREFORE RESOLVE THAT:***

As the standards for implementing national health reform are being developed, it is essential that they recognize and protect the indispensable role that licensed insurance professionals play in serving consumers. It is important for federal policymakers to acknowledge the critical role of producers and to establish standards for the Exchanges so that insurance professionals will continue to be adequately compensated for the services they provide, and so that the duties of Exchange Navigators appropriately reflect the important role of insurance producers who are skilled, knowledgeable, educated and licensed and regulated.



September  
2006

# ISSUE BRIEF

## AMERICAN ACADEMY of ACTUARIES

### Wading Through Medical Insurance Pools: A Primer

*Policymakers have been exploring the use of pooling mechanisms as a means to expand the availability of health care coverage. Discussions at both the federal and state levels have focused on medical insurance pools and their potential to provide more stable and affordable health insurance coverage.*

*Pooling is essential for a viable insurance program, but by itself it's no guarantee. As policymakers explore the use of alternative pooling arrangements involving different rating mechanisms and/or benefit requirements, it is important to understand how these alternatives will affect existing pools, and how existing pools will affect the new pools. Pooling must use techniques to minimize selection in a voluntary insurance market. Otherwise, pools that attract those with higher expected claims will have higher rates and a premium spiral could result unless subsidized by some mechanism.*

*This issue brief describes the types of medical insurance pools, highlights issues that are fundamental to pooling, and illustrates how changes within a multiple small-employer pool would affect medical costs. The paper also describes different rating methods and examines the potential effects of introducing a new rating mechanism in an existing insurance market.*

#### Medical Insurance Pools

The pooling of risk is fundamental to all types of insurance because large pools of similar risks exhibit stable and measurable characteristics that enable actuaries to estimate future costs within an acceptable range of accuracy. This, in turn, enables actuaries to determine premium levels that will generally be sufficient to fund claims and administrative costs that are stable over time, relative to overall cost trends. While this paper focuses on medical insurance, the ability to ac-

*The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.*

*Members of the Small Group Market Task Force include: Karen Bender, ASA, MAAA, FCA, Chairperson; Ronald E. Bachman, MAAA, FSA; David J. Bahn, MAAA, FSA; James E. Drennan, MAAA, FCA, FSA; John D. Fleming, MAAA, ASA; Leonard Koloms, MAAA, FSA; Richard M. Niemiec, MAAA; David A. Shea Jr., MAAA, FSA; Martha M. Spenny, MAAA, FSA; Mark D. Wernicke, MAAA, FSA; and Jeffrey Miller, MAAA, FCA, FSA, MCA.*



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curately estimate adequate premium levels is the foundation of insurance and also applies to other insurance lines, including life and property and casualty.

In simplest terms, medical insurance pools are large groups of individual entities (either individuals or employers) whose medical costs (claims) are combined for evaluating financial experience and/or determining premiums. The size of the pool may vary from a few hundred individuals to hundreds of thousand. Every pool has eligibility requirements for individual members. Eligibility requirements such as employment, group size, or association membership, for example, are the key elements that bind members of the pool together.

How groups are pooled and how premiums vary within a pool depends on many factors, including state laws, the regulatory environment, and insurer practices. Because these factors vary by state, pooling practices and rating practices vary.

## Types of Medical Insurance Pools

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### *Large-Employer Pools*

All pools are formed for the purpose of combining the medical experience of its members in order to make future claims more predictable. Large employers (generally more than 1,000 employees) almost universally will have a pool consisting solely of their own employees with premiums generated entirely from the claims of their employees and dependents, although some employers also include retirees and their dependents within the pool. Pool membership is usually automatic, with a very large percentage of employees participating due to the significant premium subsidies the employer often provides. (The process of electing — or not electing — to participate in a health insurance program is referred to as “selection” as well as “take up” and it plays a critical role in the success or failure of any medical insurance pool. This will be discussed in more detail later in the paper.) A large-employer pool is formed as an incidental by-product of the employer’s business processes and activities and eligibility for such a pool is based solely on an individual’s employment with the large employer. Employment can be thought of as the “glue” that binds the pool members together.

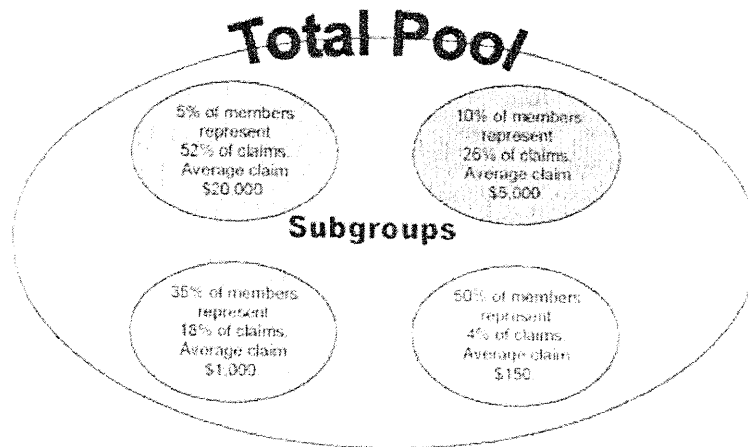
Pool members are generally diverse as far as age, gender, and health status. If there are enough members, their diversity produces fairly stable medical utilization and claims that can be used as the basis for predicting future premiums. In contrast, pools with low membership can experience extreme fluctuations in utilization and claims.

Some individuals are high users of more intensive services and are considered higher risks, while others who use fewer services are considered lower risks. **In every pool the healthier risks subsidize the unhealthy risks. For a pool to remain viable and intact, it must be of sufficient size to reflect a balanced cross-section of risks.** If a pool is composed only of high risks, the premiums will be high. In a voluntary market, high premiums result in healthier risks electing (or selecting) not to participate because they do not perceive the premiums as being a wise economical purchase. As a result, the pool is made up of a disproportionate share of less healthy risks. Anti-selection results when there is no economic incentive for healthy individuals to purchase insurance. Anti-selection is partially mitigated in a large, single-employer pool because the employer generally funds the majority of the premium, providing a very real economic incentive for employees to participate regardless of their health risks. Since the employees are not responsible for the majority of the cost of the program, their expected return in the form of claim compensation is equal to or greater than the premium contributions they make.

The employer further limits selection by requiring members to enroll only at a certain time — when they become first eligible (after completion of any probationary period) and at annual open enrollments. Benefits are often limited for the treatment of pre-existing conditions for individuals who waived insurance entirely when they were first eligible and now want to participate. These enrollment restrictions, coupled with limited benefits for pre-existing conditions, help minimize the possibility of “just in time” insurance where employees would delay the purchase of insurance until they need care. Employment practices and processes act as the “glue” that keep pool members intact and provide a barrier against entry by a disproportionate number of high risks.

Figure A illustrates a distribution of claims and the members with claims at those levels for a typical large employer:

FIGURE A



**Note:** The information provided in Figure A is for illustrative purposes only. While the magnitude of the numbers indicates experience for large employers in general, the actual numbers for any particular employer would vary.

The employer decides the level of benefits offered, the choice of benefits, and the amount of subsidy provided. Decisions left to individual employees are generally limited to participation (take-up) in the pool and choice of benefit plan. Because of the employer subsidy, take-up rates have historically been very high. A large employer essentially makes the health care decisions for the employees rather than individual employees electing to seek coverage on their own.

#### *Individual Pools*

Pools of individuals who purchase insurance are at the other end of the choice spectrum. Individuals must actively seek and purchase medical insurance and must fund the entire cost of the premium in addition to all cost sharing provisions of the benefit plan. Individuals join the pool solely because they want to purchase insurance, not because they are already members of another group, such as employees. Adverse selection is therefore a major concern in the individual market. Individuals must apply for membership in the pool and must meet explicit membership requirements, which can vary by the particular pool. These requirements will have different effects on claim costs.

The lowest claim costs are evident in pools where individuals must satisfy an insurer's medical underwriting requirements. The requirements may be loose, requiring only a series of answers on an application for coverage, resulting in a fairly high number of unhealthy members. Or the requirements may be stringent, requiring physician statements and blood and fluid tests, resulting in healthier members. More stringent requirements will generally produce pools with lower initial claim costs than in pools with less stringent requirements. The underwriting process is generally applied on an individual basis, thus an applicant may be accepted while a dependent is rejected. The effects of underwriting wear off over time as individuals who were healthy at the time of application acquire new health conditions. Even pools that combine individuals who were previously underwritten with an ongoing stream of new entrants, however, will have lower overall claim costs than pools without underwriting.

The highest claim costs are in pools composed of high-risk or uninsurable individuals, called high-risk pools. Typically, individuals must have been rejected by one or more insurance companies for medical reasons to enroll in a high-risk pool. Medical costs in these pools will be very high because they are composed only of sick people with serious health conditions who are expected to be high users of medical services. While the premiums for high-risk groups are typically 150 percent of the premium in the individual market for a standard risk (or higher), they are usually insufficient to fund claims and administrative expenses and therefore need to be subsidized by outside sources.<sup>1</sup> A pool composed of high-risk individuals will not result in low premiums and

<sup>1</sup>Comprehensive Health Insurance for High-Risk Individuals, Nineteenth Edition, 2005/2006, published by CA, Inc. in cooperation with the National Association of State Comprehensive Health Insurance Plans.

will not be self-sustaining. **Merely forming a pool will not automatically guarantee that costs will stay low and stable in the future.**

*Merely forming a pool will not automatically guarantee that costs will stay low and stable in the future.*

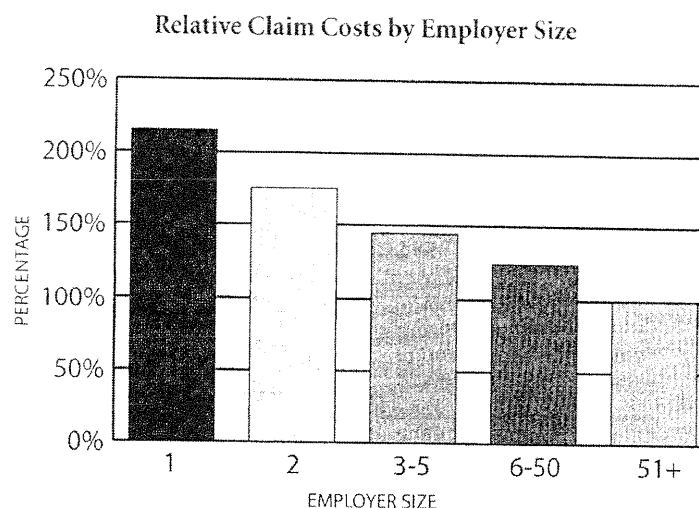
#### **Other Medical Pools**

Sometimes insurers pool several mid-size employers together. The premiums for any specific employer will be a blend of their own experience and the experience of the pool as a whole. The aggregate medical costs in these pools, however, will approach those of a large employer because the pool is incidental to other business processes and activities and mid-size employers will generally have similar demographics and health risks.

Other pools may be composed of many small employers with a large combined membership. The experience of all employers is pooled to determine basic premium costs, although the premiums for any specific employer may vary based on demographics and the health status of its employees and/or dependents. The demographics for any specific small employer may not be indicative of the demographics of the overall pool because there are not enough employees in any specific small employer group to reflect the entire spectrum of risk. Insurance for individuals in these pools is not typically underwritten. Since small employers are not required to offer insurance programs, either legally or competitively, those who do offer such coverage often have higher claim costs due to the individual selection involved in the employees' decision to purchase (a common example is for an owner to offer insurance to secure coverage for his/her self and dependents). Pools of small employers may also have higher claims costs because small employers often do not have the stringent employment requirements that large employers may have. Large employers are more apt to have formal processes in place to selectively recruit employees who meet physical requirements for certain jobs, for example, while small employers typically do not have such employment requirements.

Figure B illustrates relative claim costs by employer size using the costs for groups with more than 50 employees as the base for comparison in a state requiring that group insurance be offered to employers with one or more lives. In this state, insuring entities were required to provide guarantee-issue coverage to groups of one (self-employed individuals) within the same rating bands as they were required to use for small employer groups (groups of between two and 50 employees). The Health Insurance Portability and Accountability Act (HIPAA) requires insurance companies to provide guarantee-issue coverage to employer groups of between two and 50 employees.

**FIGURE B**



**Note:** The information provided in Figure B is for illustrative purposes only. While the magnitude of the numbers indicates real experience, the actual numbers would vary.

## Other Issues

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### *Decision Making*

A single employer makes the purchasing decisions for all employees, serving as the “glue” that holds employees together. For a block of 333 employers with 3 lives each, there are 333 purchasing decisions, so the “glue” is very thin and weak. There is no guarantee that all 333 groups will remain in the insurance pool or that there would be replacements for those who leave. A single 999-employee group will almost always form a pool, where the “glue” is very thick and strong.

*A single employer with 999 employees is not the same as 333 groups with 3 employees each.*

### *Administrative Costs*

Just as forming a pool does not automatically result in lower medical costs, a pool also does not necessarily result in lower administrative expenses. The administrative costs in a pool of small employers vs. a large-employer pool may be classified differently, but the actual costs would likely be similar. Large employers have human resource departments to handle health insurance issues such as enrollment and premium collection. They will often use benefit consultants instead of an insurer's staff for plan design issues. Small employers, especially very small employers, use insurance agents, who receive a commission for their services, to sell the plan, enroll employees, and serve as a liaison with the insurer. Thus the administrative expenses for large groups vs. small groups are likely not comparable. There are some administrative expenses that are greater for small groups, such as billing and initial underwriting. Other administrative functions, such as paying claims, compliance, or provider negotiations, offer little opportunity for expense savings in any medical insurance pool.

### *Provider Reimbursement*

Large insuring entities that have members concentrated in a confined geographic area are often able to negotiate more favorable provider reimbursement levels than an insuring entity of the same size whose membership is distributed across several states or which has smaller insuring entities. It is common practice for an insurer to make the same provider reimbursement levels (hospital or physician charges) available to each of the pools it manages.

## Managing A Multiple Small-Employer Pool

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A multiple small-employer pool typically consists of employers with two to 50 employees. Evaluating financial results and determining necessary premiums are an important part of managing a multiple small-employer medical insurance pool. Determining the expected medical costs can be difficult if, for example, there are changes in the size mix of small employers in the pool. For individual insurance, the average duration since issue is a determinant of medical costs. Once medical costs are determined, there may be stringent rules regulating rate increases or premium rates. The effect of these regulations on the financial expectations of the pool requires careful consideration since they can affect the pool's viability.

Managing the effects of anti-selection is a crucial element of a successful pool:

- In a voluntary insurance market where individual units (be they employer units or individuals) elect whether to purchase insurance, selection occurs.
- A goal of insurance is to minimize anti-selection.
- Pooling can minimize anti-selection or increase it.

For illustrative purposes, Table 1 reflects the typical distribution of pool members by size of claim as previously shown in Figure A. In this baseline example, 35 percent of members have an average claim of \$1,000, and 5 percent of members have an average claim of \$20,000. The average claim per member of the pool is \$1,925.

TABLE 1

Baseline Membership Distribution and Baseline Claim Costs				
Members		Claims		
Number	Percent	Average Claim Size	Total Claims	Percent of Total Claims
[A]		[B]	[A] x [B]	
500	50%	\$150	\$75,000	4%
350	35%	\$1,000	\$350,000	18%
100	10%	\$5,000	\$500,000	26%
50	5%	\$20,000	\$1,000,000	52%
1,000	100%	<b>\$1,925</b>	<b>\$1,925,000</b>	<b>100%</b>

Successfully managed pools will produce an increase in the average claim cost equal only to the average of provider price increases and overall average utilization increases. In this case, with other things being equal (i.e. no new groups being introduced), members of a subsegment will not have a strong reason to leave the pool since healthy members will not find a “better deal” elsewhere. Table 2 illustrates the outcome if there were a 10 percent provider price increase. For simplicity, the examples assume no utilization increases.

TABLE 2

Baseline Distribution with a 10% Provider Increase in Cost				
Members		Claims		
Number	Percent	Average Claim Size	Total Claims	Percent of Total Claims
[A]		[B]	[A] x [B]	
500	50%	\$165.00	\$82,500	4%
350	35%	\$1,100.00	\$385,000	18%
100	10%	\$5,500.00	\$550,000	26%
50	5%	\$22,000.00	\$1,100,000	52%
1,000	100%	<b>\$2,117.50</b>	<b>\$2,117,500</b>	<b>100%</b>
Increase from Baseline:		10%		

In Table 2, total claims and the average claim increase by 10 percent. Nevertheless, the distribution of claims equals that under the baseline example.

If the distribution of members by subsegment were to change, however, the equilibrium of the pool could change, resulting in an increase above the average claim cost in Table 1. (Although the result could be a smaller claim cost, this is rare.) Table 3 illustrates how a very minor shift in the distribution of claims costs can produce a significant increase in the average claim cost.

TABLE 3

Change in Baseline Distribution no Provider Increase in Cost				
Members		Claims		
Number	Percent	Average Claim Size	Total Claims	Percent of Total Claims
[A]		[B]	[A] x [B]	
450	45%	\$150.00	\$67,500	3%
370	37%	\$1,000.00	\$370,000	18%
130	13%	\$5,000.00	\$650,000	31%
50	5%	\$20,000.00	\$1,000,000	48%
1,000	100%	\$2,087.50	\$2,087,500	100%
Increase from Baseline:		8%		

In Table 3, the share of members with the lowest average claim of \$150 decreases from 50 percent to 45 percent, and the shares with averages of \$1,000 and \$5,000 increase from 35 percent to 37 percent, and from 10 percent to 13 percent, respectively. The relatively small shift in the distribution of claims increases the overall average per member by 8 percent, from \$1,925 to \$2,088.

If this member shift is combined with the 10 percent provider price increase, the average claim per member increases even further, as illustrated by Table 4.

TABLE 4

Change in Baseline Distribution and a 10% Provider Increase in Cost				
Members		Claims		
Number	Percent	Average Claim Size	Total Claims	Percent of Total Claims
[A]		[B]	[A] x [B]	
450	45%	\$165.00	\$74,250	4%
370	37%	\$1,100.00	\$407,000	19%
130	13%	\$5,500.00	\$715,000	34%
50	5%	\$22,000.00	\$1,100,000	53%
1,000	100%	\$2,296.25	\$2,296,250	110%
Increase from Baseline:		19%		

The combination of the 10 percent increase in provider payments and the shift in membership distribution to higher claim classes results in a 19 percent increase in the average claim per member. The average claim per member underlies the premiums paid by employers/members. An increase of 19 percent could be an inducement for those in the lower cost subsegments to leave the pool since:

- Individual units will seek to maximize their own economic interests through the selection process, if allowed.
- Insuring entities have an economic interest to attract lowest-cost risks, if allowed.

## Management Techniques

Several years ago, many states allowed insurers to manage and price their small-employer pools with little regulation, resulting in excessive rate increases and re-underwriting, and the use of other techniques to force employers to drop coverage. Such practices would generally be considered unacceptable today and states have since adopted regulations to limit the premiums paid by members of an insurer's small-employer pool relative to other members in the pool. The federal government has enacted HIPAA, which requires guaranteed issue for groups of between two and 50, allowing employers the ability to renew coverage. HIPAA does not, however, address rate regulation.

States commonly use the following three rating methods:

**Pure Community Rating (PCR).** Every member of an insurer's pool within the same geographic area pays the same premium rate.

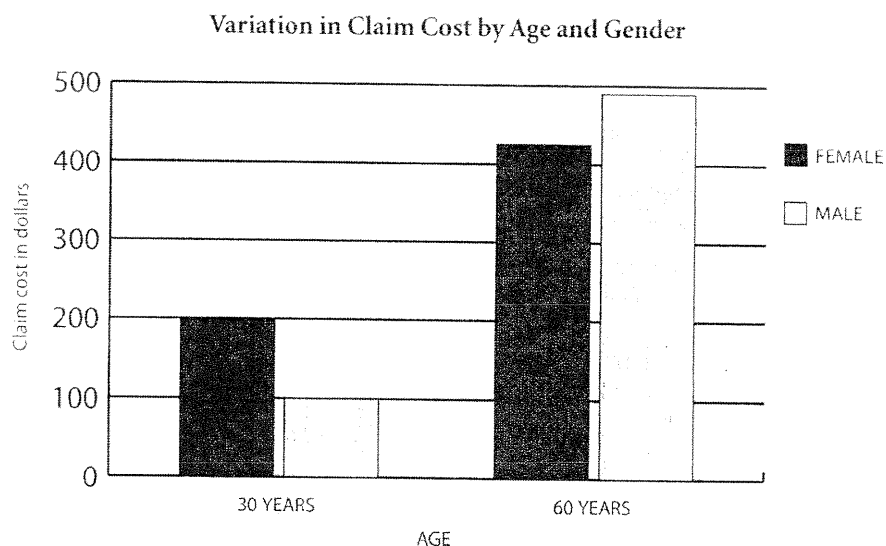
**Modified Community Rating (MCR).** Premium rates may vary by age and gender (generally) but not by health status or the employer group's claims experience.

**Variations of the Initial NAIC Rating Model (NAIC).** Rates may vary by age and gender and by limited percentages based on health status and claims experience. These limits are frequently +25 percent to +35 percent of the average rate, although some states may have higher or lower limits. There may also be limits on annual rate increases attributable to changes in morbidity, which is the relative health status of all the members of a particular employer group.

Each of the above techniques has the potential to produce stable pool experience over time, although the ability to attract a broad distribution of risks varies. The pure community rating technique is most effective at improving premium affordability for older and less healthy groups. Employers with young and healthy members, however, are less likely to participate because their premiums could be much higher than the expected value of the coverage. In effect, the distribution of enrollees would shift toward those with higher claims costs, resulting in an increase in premiums as illustrated in Tables 3 and 4.

Modified community rating reflects significant differences by gender and age (see Figure C). Employers with younger employees are induced to join and remain in the pool because their premium costs are lower. An employer with older employees, however, may be less likely to join the pool, and more likely to leave the pool, because of higher premium costs.

Figure C



**Source:** The information provided in Figure C is for illustrative purposes only. While the magnitude of the numbers indicates real experience, the actual numbers would vary.

The NAIC rating method normally combines variations within limited percentages based on health status and claims experience with age and gender rating. This approach produces a wide range in premium rates, often resulting in a more stable pool. Younger and healthier groups who are encouraged to join and stay in the pool subsidize the premiums for the older and sicker groups. While older and sicker groups pay higher premiums under the NAIC model than they would under other rating methods, they still receive subsidies from the younger and healthier groups that help fund claim expenses. Limitations on rates and rate increases may induce “sicker” groups to remain in the pool.

## Introducing Pools with Different Rating Mechanisms

Recent proposals would allow the introduction of new pools potentially using rating techniques different from those currently required in the states. Benefits offered in the new pools may also be different from those currently required. The impact of a new rating system on a state’s insurance market will vary based on the rating rule restrictions in current state regulations. Pure community rating is typically the most restrictive rating technique, while the NAIC rating method is the least restrictive, and modified community rating lies somewhere in between. The impact of introducing alternative benefit packages will also vary based on a state’s current benefit package requirements.

Introducing a pool into a state with less restrictive rating requirements may induce younger and healthier groups to join the new pool and older and less healthy groups to remain in the existing pool because of the significant differences in premiums by age and/or health status. For instance, introducing a new pool with modified community rating into a state with pure community rating could result in the pure community rating pool having an even higher average age and higher costs over time. This could create a “rate spiral,” making insurance very expensive and unattractive for all but the sickest individuals in the pool. Introducing a pool regulated under the NAIC rating rules, which allows age and gender rating, into an existing modified community rating state may have similar results. It could induce some employers to join the new pool if the age/gender rating factors are not comparable between the two pools. Employers will seek the pool that maximizes their economic well being, (i.e., the lowest rates for similar benefits). Employer groups that previously were subsidizing other groups will have an economic interest to join the pool that requires them to contribute the least subsidy. Similarly, groups that are currently enjoying a high subsidy from other groups will have an economic interest to remain in the pool that provides them the greatest subsidy.

Employers may also be induced to join a new pool if benefits offered in the new pool are significantly less than those required in the existing pool. For example, groups whose members do not use mandated benefits would be induced to join a pool without those benefits and with correspondingly lower premiums. The old pool will have higher premiums since it will be disproportionately composed of enrollees who will use the mandated benefits.

Introducing a pool with more restrictive rating requirements into a state using the NAIC rating method will similarly result in market segmentation. Groups with expected claim costs and premiums that are higher than the existing rates will join the new pool to obtain lower rates. Groups with lower expected claim costs and premiums than the new pool is allowed to charge, however, will have an incentive to stay in the existing pool. This, in turn, will result in the existing pool being composed of a larger than expected share of healthy groups, which will drive the premiums further down. The new pool, however, will not have enough healthy groups to subsidize the premiums for the older/sicker groups. The premiums for this new pool will increase, encouraging more groups in the new pool to consider the existing pool, which will drive even more healthy groups out of the new pool. The process of driving healthier risks out of a pool is often called an assessment spiral or a death spiral because once it begins, it is usually the precursor to the death of the pool. This will be true whether the premium rate differential is due to less generous benefits or lower “experience adjustments” built into the new pool rates.



## Conclusion

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Pooling is essential for a healthy insurance program, but it does not by itself, guarantee viability. Policymakers need to understand the advantages of pooling, but also the dangers that can occur if pools are disrupted by market reforms. If all pools have to abide by the same rules that do not encourage selection, then anti-selection could be minimized. Allowing different rules within the same market will doom a pool that has the more stringent requirements, and will result in market disruption. Medical insurance is a balance of encouraging enough healthy risks to enroll to subsidize the unhealthy risks that will have the economic incentive to participate. Care must be taken to develop policies that will result in maximizing the enrollment of these healthy risks while not pricing the unhealthy risks out of the market.

Policymakers often have to balance competing goals of increased access (availability to all members) and increased affordability (lower premiums.) These goals can produce difficult choices that could result in unintended consequences. Policymakers should be mindful of both the favorable and unfavorable potential consequences of these choices as they consider new approaches to increase access and affordability in health coverage.

### Hypothetical Insurance Market Demonstrating Adverse Selection

(This is a simple model for the sake of example, in the real world there are more factors)

Suppose you have a population of one hundred (100) families. One family consumes five hundred thousand dollars (\$500,000) in health care per year. The other ninety-nine (99) families consume one thousand dollars (\$1,000) each per year in health care per year. This leaves the average health care consumption of a family for the group at five thousand nine hundred and ninety-nine dollars (\$5,990) per year.

If fifty (50) of the healthier families decide not to buy health insurance, you're left with one (1) family consuming five hundred thousand dollars (\$500,000) per year and forty-nine (49) families consuming one thousand dollars (\$1,000) each per year. Because you only have fifty (50) families, the average health care consumption jumps to ten thousand nine hundred and eighty dollars (\$10,980) per year.

If only ten (10) families buy health insurance, the one (1) family with high consumption and nine (9) healthy families, the average health care consumption jumps to fifty thousand nine hundred dollars (\$50,900) per year.

HEALTH  
REFORM

A state's challenge to the federal health reform law gets the green light.

A district court overrules the federal government's procedural objections and allows a suit by Virginia to proceed. Virginia claims that the portion of U.S. law requiring people to have health insurance by 2014 or pay a fine is unconstitutional and conflicts with a contrary state law. The federal government wanted the court to dismiss the state's lawsuit prior to holding a trial (Virginia v. Sebelius, D.C., Va.). Whatever the trial court decides, the Supreme Court will end up having the final say.

Note the IRS' limited enforcement remedies if the coverage penalty is valid:

It is barred from filing a lien or placing a levy on an individual's assets to collect. Nor would interest be charged on unpaid penalties. In essence, the Revenue Service would be able to collect the fine only by offsetting refunds due the uninsured filer.

PAYROLL  
TAXES

Hiring formerly self-employed workers won't nix a 2010 payroll tax break.

Employers can claim the Social Security tax exemption for them, IRS says, as long as they haven't worked as an employee for over 40 hours in the past 60 days. If they were self-employed during that period, the credit can be claimed on their pay. The 6.2% payroll tax exemption is available for wages paid after March 18, 2010 and before 2011 to qualifying employees who were hired after Feb. 3, 2010.

Laid off workers who are rehired are eligible if they meet the 40-hour test.

So are minors. Although they're under age 18, they can sign Form W-11 to certify that they haven't worked more than 40 hours in the previous 60 days.

Earned income credit recipients are losing the advance payment option.

Currently, filers who are eligible for this credit can elect to have it paid out to them in advance. The amount of the credit for the pay period is added to their paycheck and is computed in IRS tables. But a new law eliminates this option after 2010 because only 3% of eligible earned income credit recipients take advantage of it.

PREPARERS

More details are dribbling out on IRS' upcoming regulation of tax preparers.

Starting with 2010 returns, all paid preparers will have to register with IRS and pay a fee of \$64.25 to get a preparer ID number to enter on returns. In addition, unenrolled return preparers...those other than lawyers, CPAs and enrolled agents... will have to pass competency tests and satisfy continuing education requirements.

Testing will begin in mid-2011. Those who register and get an ID number before the testing regime is up and running will have until the end of 2013 to pass. In the interim, they can still validly prepare tax returns for 2010, 2011 and 2012. They can take the tests multiple times, but they will have to pay a fee each time. A third party will give the tests at various locations...They won't be available online. Commercial firms are expected to offer test preparation courses. IRS won't do so.

ENFORCE-  
MENT

Corporations with \$50 million or less in assets will face major audit heat.

IRS is planning 22,000 line-by-line examinations, beginning next year. Tax returns for 2009 will be examined randomly across a number of industries. IRS will use the data from these exams to update its formulas for selecting returns. A new report says that 32% of recent audits of these small and midsize companies resulted in no change, wasting taxpayers' time and the Service's audit resources. That should help it significantly reduce the number of no-change examinations, if history is a guide. After the return selection formulas were revised for individuals, the no-change rate for returns examined by revenue agents decreased to just 10%.

Yours very truly,

*The Kiplinger Editors*  
THE KIPLINGER WASHINGTON EDITORS

Aug. 20, 2010

## Savings From HSAs

Employer with 4 Employees in Waterville 2009 rates.

### I. Assumption: Employer pays 100% of the Employees coverage, nothing for family

Cost for one Employee

Aetna

HMO 1	572	per month
PPO 7	<u>217</u>	per month
Savings	355	per month
	<u>*12</u>	
	\$4,260	per year

If Employer contributes \$3000 per year to HSA, they still save \$1,260 per year.  
PPO 7 is a \$3000 deductible plan, HMO 1 is rich benefit HMO.

### II. Ten years later

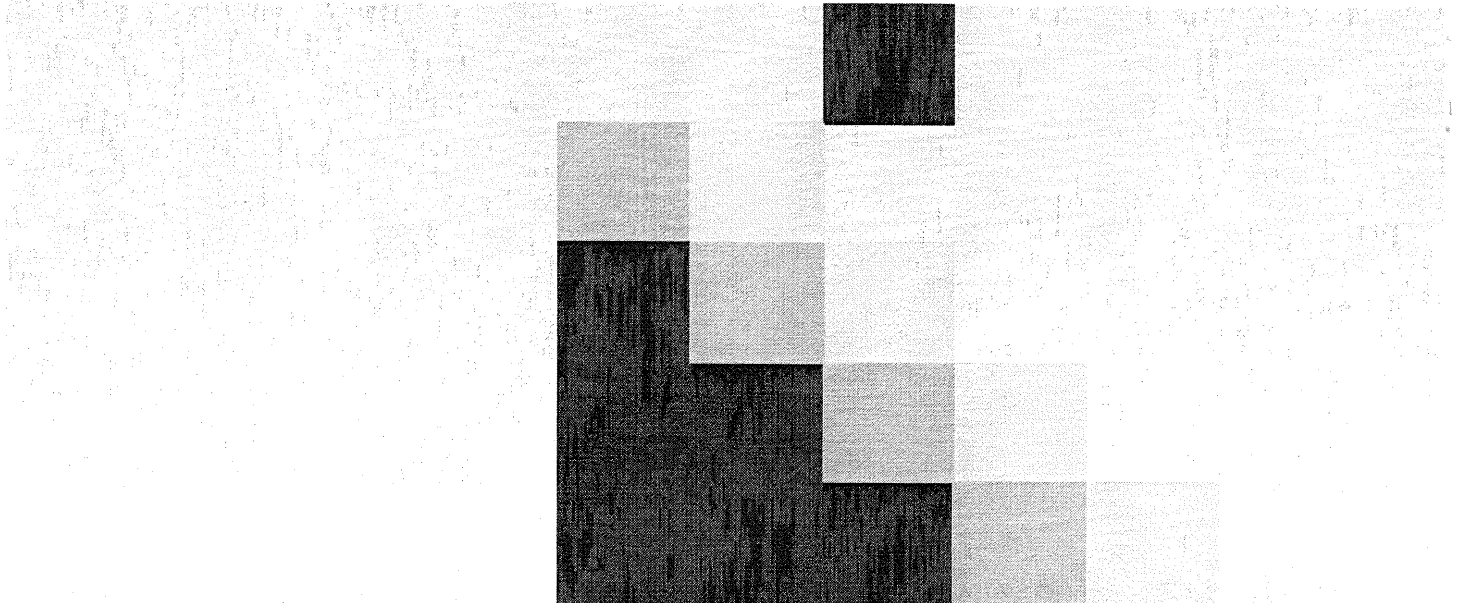
Assumptions: Premium increase by 8% per year; employee averages \$1000 per year in uncovered health care expenses; employee earns 5% on the money in the HSA; 8% per year growth in health care expenses.

Cost for one Employee in ten years

Aetna

HMO 1	1143.39	per month
PPO 7	<u>433.71</u>	per month
Savings	709.68	per month
	<u>* 12</u>	
Savings	\$ 8516.16	per year

Amount in HSA with \$3000 per year contribution \$19,406.63 after ten years and based on assumptions above.



# Maine Small Group & Individual Market Study

Gorman Actuarial, LLC

May 22, 2007

# Study Focus

- Health Reforms in the Maine Market Were Modeled and Analyzed
  - Merging Individual & Small Group Markets
  - Introduction of a Reinsurance Program
    - Individual Market Only
    - Merged Market
  - Introduction of a High Risk Pool for the Individual Market



# Study Results

- Results of Each Analysis Show:
  - ☐ Impact to Premium Rates
  - ☐ Impact to Insured Enrollment
  - ☐ Projected Funding Requirement



# Study Population & Data

- Participating Insurance Carriers
  - ☐ Anthem Blue Cross & Blue Shield of Maine
  - ☐ Aetna
  - ☐ MEGA
- Individual Market
  - ☐ Member Level Detail
  - ☐ Includes Dirigo Population (Individual and Sole Proprietor)
  - ☐ Represents ~96% of the Entire Individual Market
- Small Group Market
  - ☐ Summary Tables
  - ☐ Includes Dirigo Population
  - ☐ Represents ~82% of the Entire Small Group Market

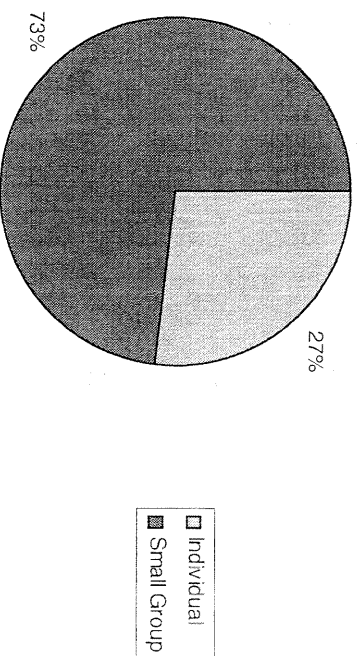


# Health Reform: Merging the Markets

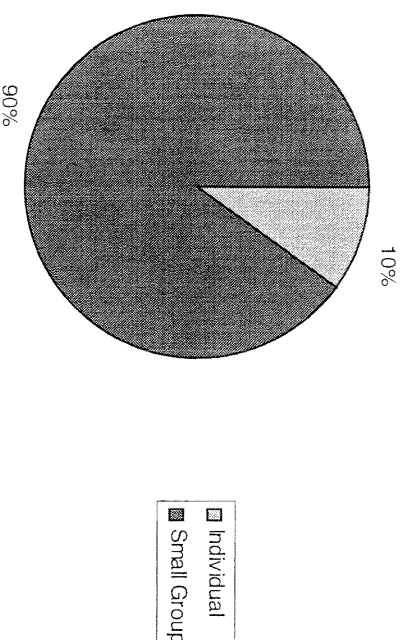
- **Current Practice Premium Rate Development**
  - Based on Claims Experience (Costs) of Each Population
  - Separate Rates are Calculated for the Small Group Market and Individual Market
- **Current Market Observations**
  - Individual Market Older than Small Group Market
  - Greater Adverse Selection in Individual Market
  - Result: Individual Market Premiums are Higher than Small Group Premiums for Similar Coverage
- **Outcome of Merging the Markets**
  - Premium Rates Based on the Combined Claims Experience
  - Individual Market Rates Decrease
  - Small Group Rates Increase Overall (Except Groups of 1-2)
  - Small Group Market Subsidizes the Individual Market

# Merged Market Market Demographics

Maine Merged Market Distribution



MA Merged Market Distribution



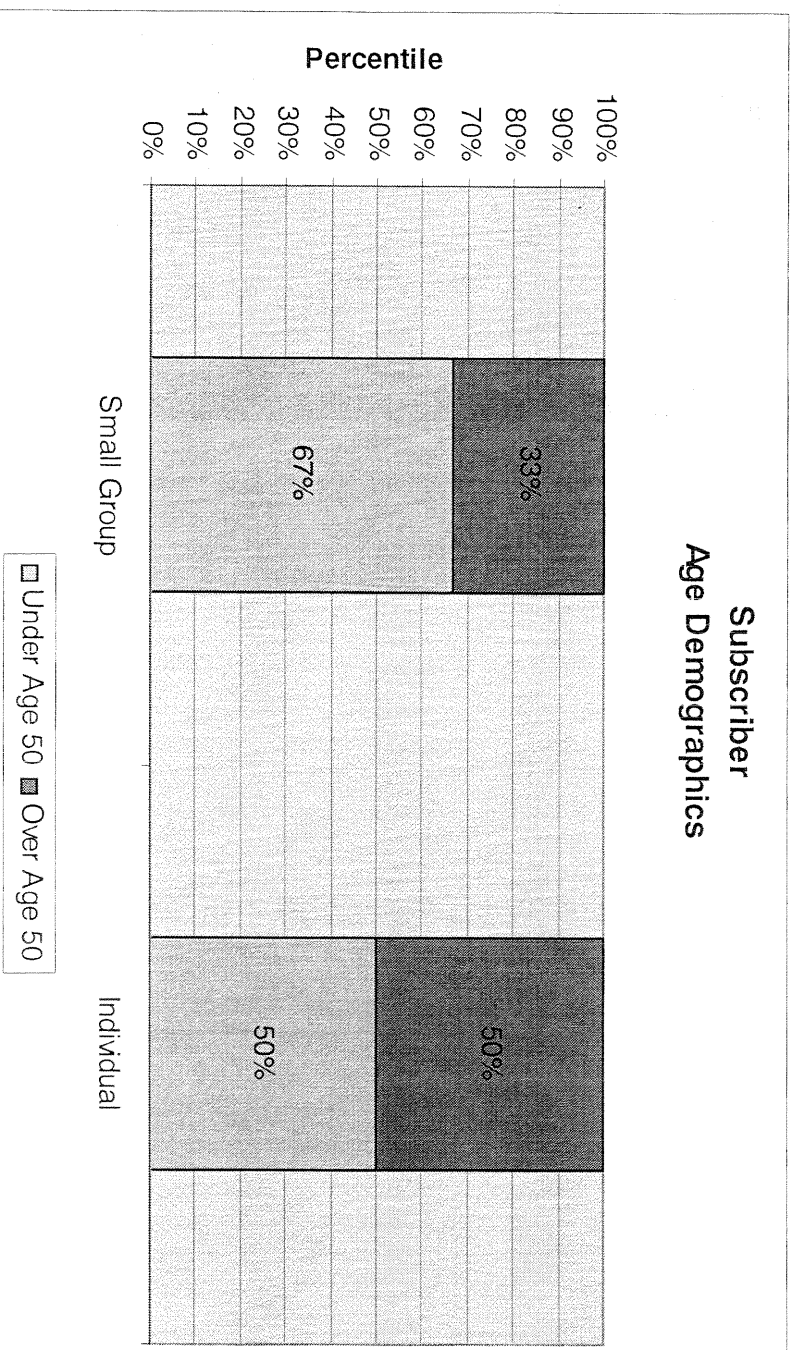
- 27% of Maine's Merged Market is in the Individual Market
  - Compared to 10% of Massachusetts Merged Market
- Group Market Must Subsidize a Greater Portion of Individual Costs

# Merged Market Benefit Levels

- Small Group Benefit Levels ~ 50% Richer
- Average Small Group Deductible is \$1000
- Average Individual Market Deductible is \$7000

Individual Market Top Benefit Levels	
Individual Deductible	Market Share
\$2,250	4%
\$5,000	51%
\$10,000	6%
\$15,000	15%

# Merged Market Age Demographics



- Individual Market is Older, with an Age Factor 15% Higher than the Small Group Market

# Merged Market Claims Experience

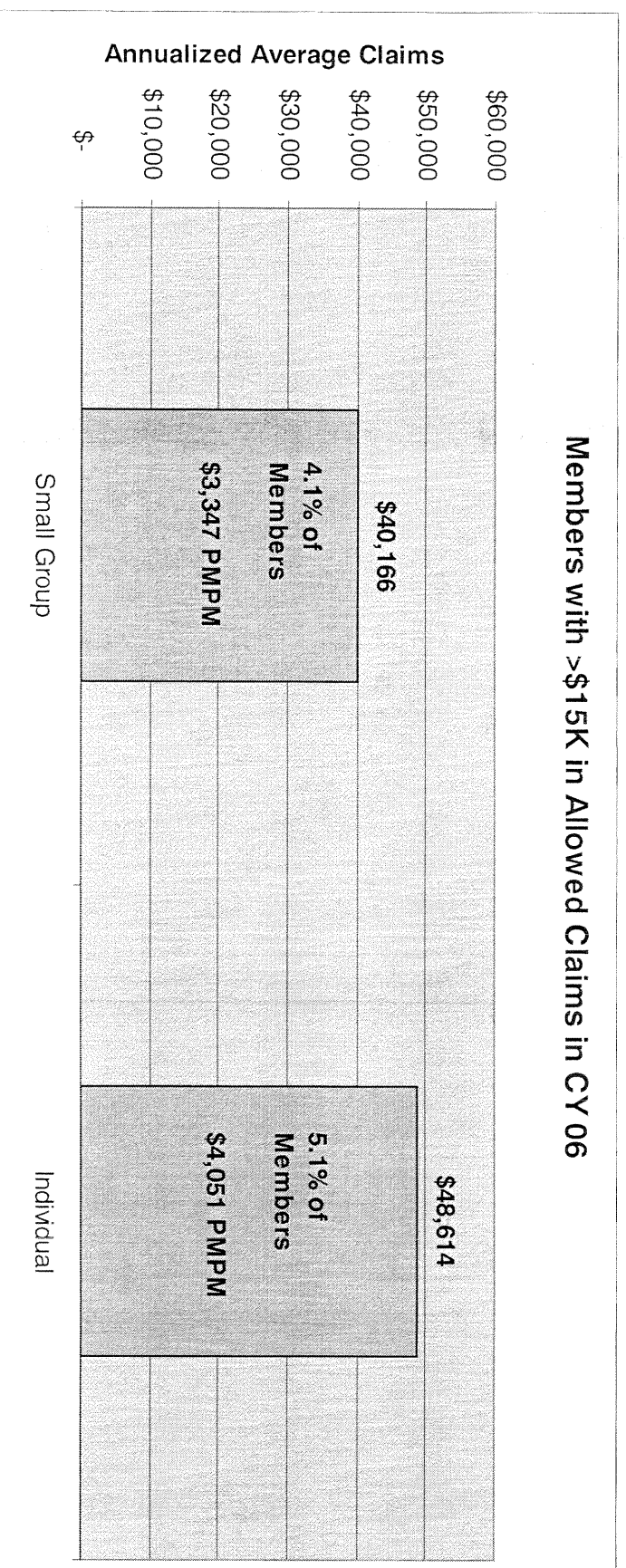
Estimated CY 2006	Allowed Claims PMPM*
Small Group	\$ 312
Individual Market	\$ 357
Total Merged Market	\$ 329

\* PMPM = Per Member Per Month

- Definition of Allowed Claims
  - Claims Costs Paid by the Insurer + Claims Costs Paid by the Member
  - Includes Member Cost Sharing
- Observations
  - Individual Market ~14% Higher than Small Group Market
  - This Difference Can Be Explained By the Age Difference
- Suggests
  - High Deductibles in Individual Market Discourage Use
  - Risk Differences May Not be Significant

# Merged Market High Cost Claimants

Members with >\$15K in Allowed Claims in CY 06

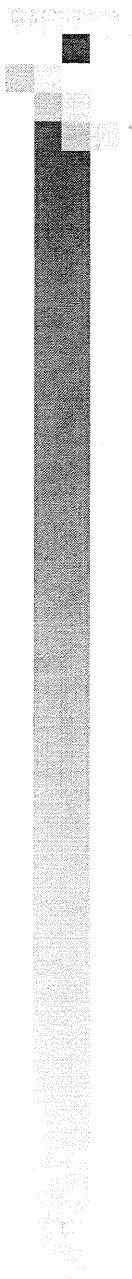


- Individual Market Has a Greater Percentage of High Costing Members
- Average Costs for Individual Market Are Higher than Small Group

# Merged Market

## Group Size Adjustment (GSA)

- Current Regulations for Group Size Adjustment
  - No Limitation for Small Group Market
  - Current Adjustments are Significant for the Smaller Groups
  - Adjustments for Groups of 1-2 are 35-50% Higher than Groups of 26-50
- Future Merged Market
  - Requires a Group Size Adjustment Limit
  - Modeled Various Limits for Sensitivity
  - Results Shown for a 1.10 and 1.20 Group Size Adjustment Limit
  - Limit Will Increase Rates for Larger Groups and Decrease Rates for Smaller Groups



# Merged Market Other Assumptions

- Membership Projections
  - Utilized an Elasticity of Demand Algorithm
  - Assumed Rate Decreases Will Increase Enrollment
  - Assumed Rate Increases Will Decrease Enrollment
- Health Status of the Uninsured
  - Assumes Health Status of Uninsured is 20% Better than Merged Market

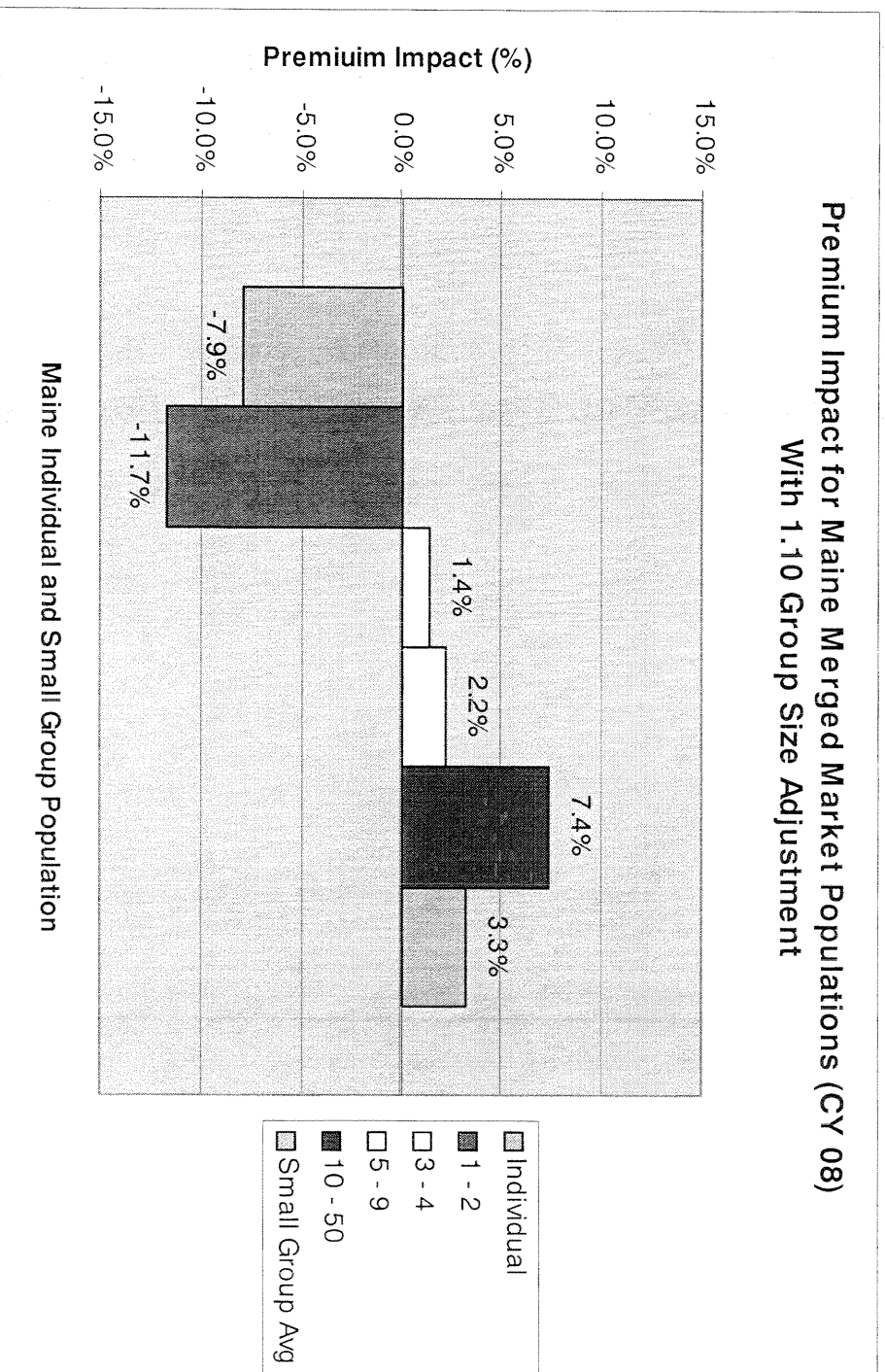


# Merged Market

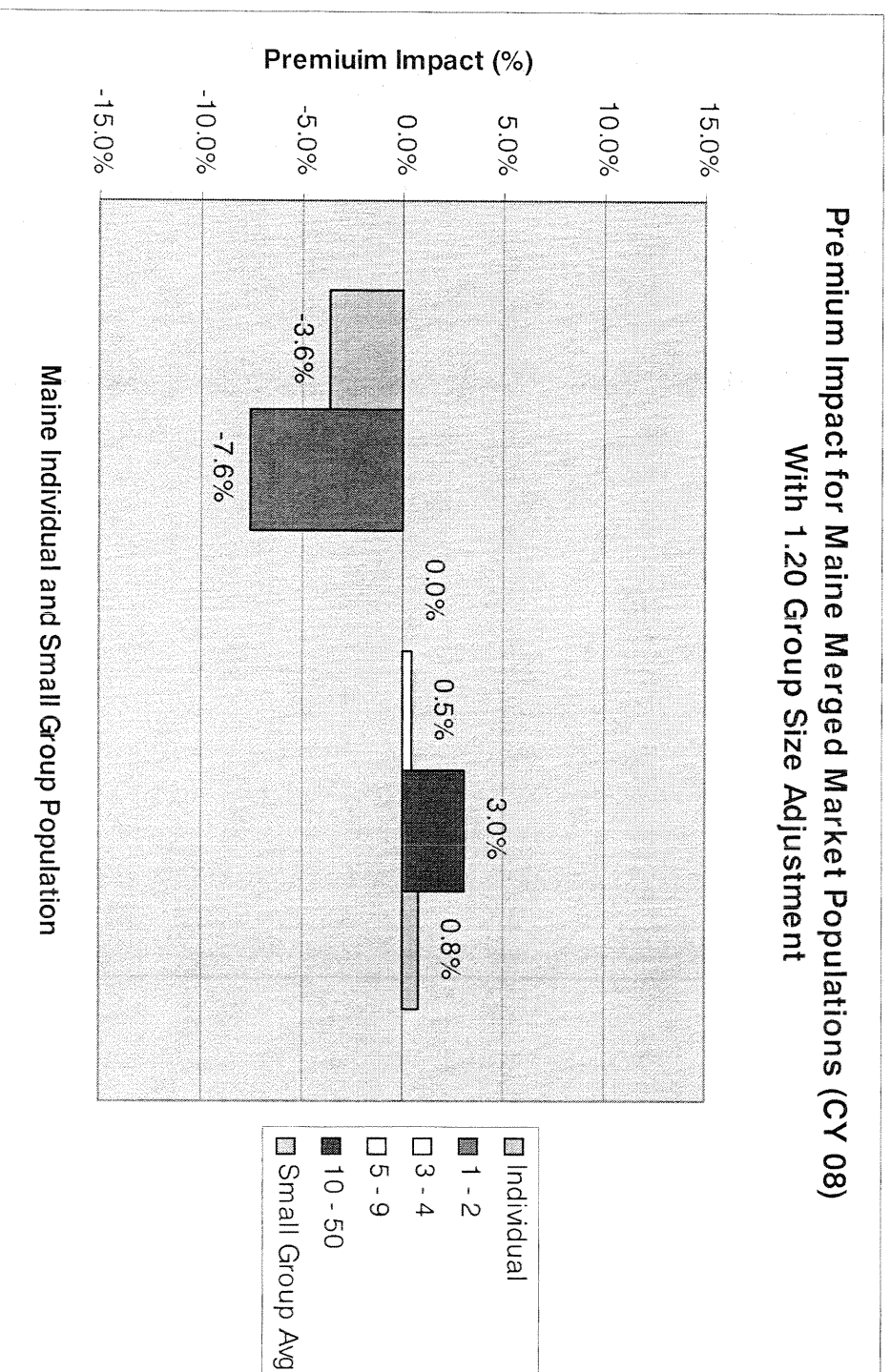
## Summary of Results

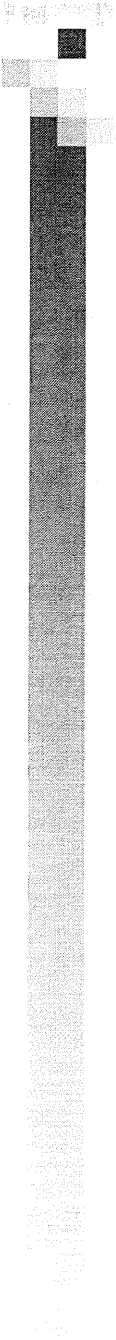
- Individual Market Rates Decrease
  - ~8% for a 1.10 Groups Size Adjustment
  - ~4% for a 1.20 Groups Size Adjustment
- Overall Small Group Rates Increase
  - ~3% for a 1.10 Groups Size Adjustment
  - ~1% for a 1.20 Groups Size Adjustment
  - Impact Varies by Group Size
- Insured Membership Increases
  - 1,348 Members for a 1.10 Groups Size Adjustment
  - 800 Members for a 1.20 Groups Size Adjustment

# Merged Market Premium Impact With 1.10 GSA



# Merged Market Premium Impact With 1.20 GSA





# Health Reform: Reinsurance Overview

- Reinsurance Can Mitigate Carrier Risk and Help Stabilize Health Insurance Markets
- Reinsurance Typically Funded Via Premium, Assessments, Taxes, or Government Funding
- Pays Loss Per Insured Exceeding a Threshold
  - Reinsure a Percentage of Member's Annual Aggregated Paid Claims That Are Either
    - Above a Threshold
    - Within a Range

# Reinsurance Study Example

*Simple Illustration*  
*Reinsurance Program: 100% > \$50,000*

	Paid Claims		Reinsured Claims		Insurer Claims After Reinsurance	
Member 1	\$	10	\$	-	\$	10
Member 2	\$	40,000	\$	-	\$	40,000
Member 3	\$	125,000	\$	75,000	\$	50,000
Total	\$	165,010	\$	75,000	\$	90,010
Per Member Costs	\$	55,003	\$	25,000	\$	30,003
Insurer Claims Reduction						-45%

# Reinsurance Model Scenarios

## Individual Market Findings

### ■ Chose Two Funding Amounts

☐ \$15M

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Dollars at (\$000,000)	Premium Impact
40,000	Infinity	50%	\$ 14.8	-10.7%
90,000	Infinity	100%	\$ 14.7	-10.6%
35,000	75,000	100%	\$ 15.0	-10.8%
50,000	200,000	80%	\$ 16.0	-11.5%

☐ \$30M

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Dollars at (\$000,000)	Premium Impact
10,000	Infinity	50%	\$ 29.6	-21.3%
30,000	Infinity	80%	\$ 28.8	-20.7%
40,000	Infinity	100%	\$ 29.6	-21.3%
5,000	20,000	100%	\$ 29.5	-21.2%
5,000	75,000	50%	\$ 28.5	-20.5%

# Reinsurance Model Scenarios

## Individual Market Findings

- Premium Impact
  - \$15M
    - 11% Premium Reduction
    - 2,300 New Insured Members
  - \$30M
    - 21% Premium Reduction
    - 4,500 New Insured Members
  - Impact Significant in Year 1
  - If Threshold Limits Are Not Indexed With Trend, Amount Required to Fund Reinsurance Will Increase Over Time

# Reinsurance Model Scenarios

## Merged Market Findings

### ■ Chose Two Funding Amounts

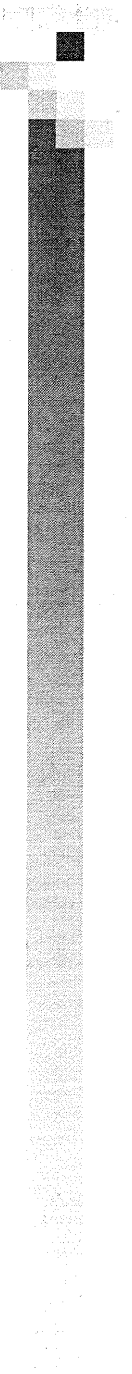
□ \$15M

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Dollars (\$000,000)	Premium Impact
150,000	Infinity	80%	\$ 15.8	-2.8%
200,000	Infinity	100%	\$ 12.7	-2.2%
30,000	50,000	50%	\$ 16.3	-2.9%
50,000	70,000	90%	\$ 16.0	-2.8%

□ \$30M

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Dollars (\$000,000)	Premium Impact
90,000	Infinity	80%	\$ 30.3	-5.3%
100,000	Infinity	90%	\$ 30.3	-5.3%
40,000	75,000	90%	\$ 30.9	-5.4%
50,000	100,000	90%	\$ 29.8	-5.2%





# Reinsurance Model Scenarios

## Merged Market Findings

- Premium Impact
  - \$15M
    - 3% Premium Reduction
    - 1,450 New Insured Members
  - \$30M
    - 5% Premium Reduction
    - 2,900 New Insured Members
  - Impact Significant in Year 1
  - If Threshold Limits Are Not Indexed With Trend, Amount Required to Fund Reinsurance Will Increase Over Time

# Health Reform: High Risk Pool

- Traditional High Risk Pool (HRP)
  - Health Underwriting By Carrier Allowed
    - Applicants Fill Out Health Questionnaires
    - Insurance Carrier Assigns a Score
    - Score is Used to Develop Premium Rates
    - Applicants May Be Denied
  - Denied Applicants May Apply to HRP
  - Members with High Premium Rates May Apply to HRP
- Applicants with Certain Conditions May Apply to HRP

# High Risk Pool Overview

## ■ HRP Financials

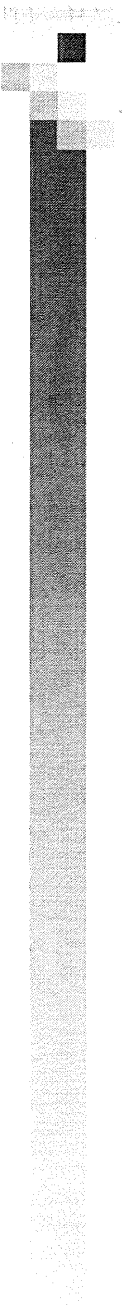
- ☐ Premium is Set at Some Percentage Higher Than Individual Market Standard Rate
- ☐ Claims Costs Typically 3-6x Higher Than Individual Market Claims
- ☐ HRP Funded Through Member Premium, Assessments, Other State Funds

## ■ Desired Results

- ☐ Improved Health Status of Individual Market
- ☐ Lower Premium Rates in Individual Market
- ☐ Increased Enrollment in Individual Market
- ☐ Less Uninsured

# High Risk Pool Model Assumptions

- Change Age Band from 1.5:1 to 4:1
- Health Status Adjustment Band of 1.5:1
- Due to Reform, Members Will Be in One of Three Pools
  - ☐ Open Block (OB)
  - ☐ High Risk Pool (HRP)
  - ☐ Closed Block (CB)
- HRP Premium is 1.25 Times Standard OB Premium Adjusted for Demographics

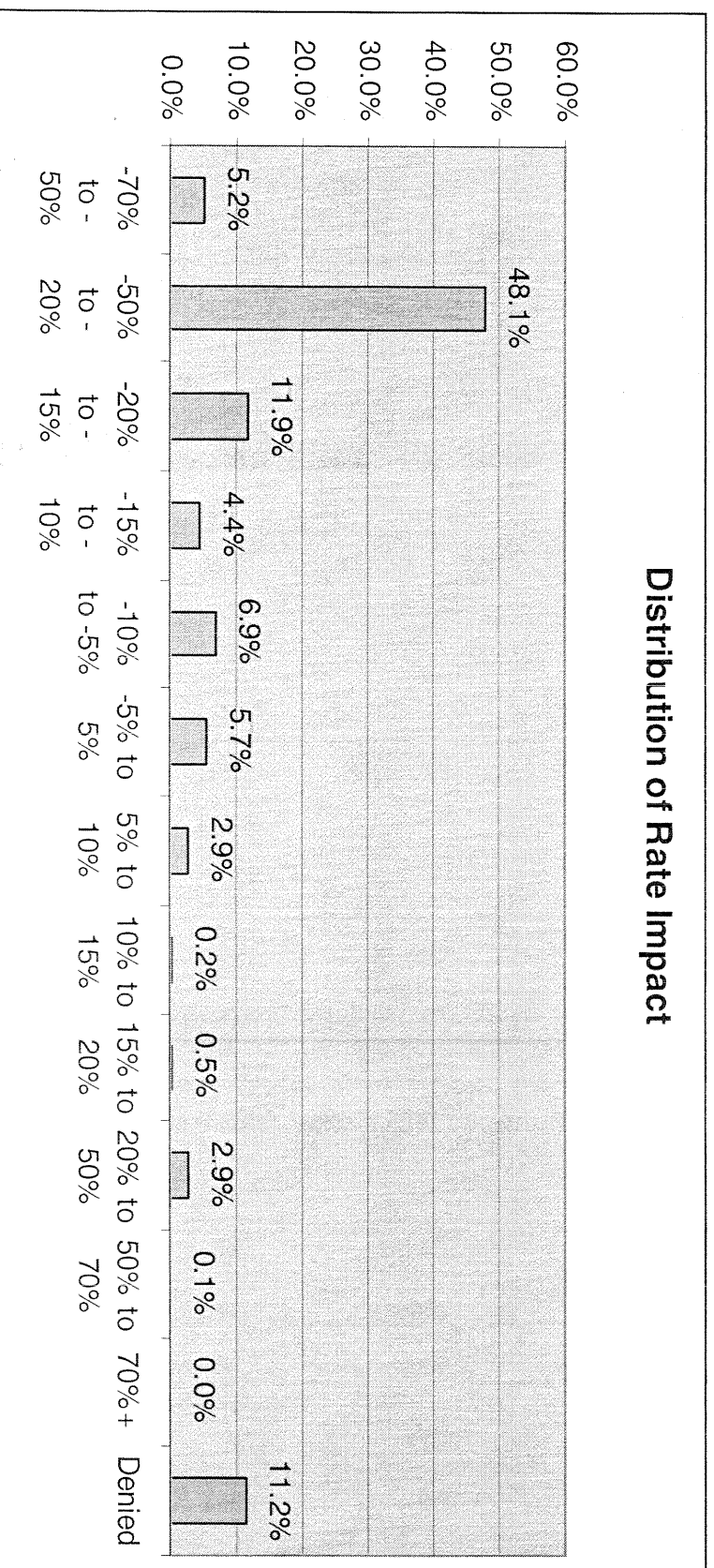


# High Risk Pool Model Assumptions

- Transition Assumptions
  - Current Population Moving to Three Pools
  - Health Status Assumptions
- Uninsured Health Status 20% Better than Insured Population (Merged Market)
- Utilized an Elasticity of Demand Algorithm
- Modeled Two Scenarios
  - Closed Block Premium Not Subsidized
  - Closed Block Premium Subsidized

# High Risk Pool Model Results

- OB Premium Impact ~ 30% Reduction
- 3,500 New Insured Members



# High Risk Pool Model Results

- Modeled High Risk Pool Results Two Ways
  - ☐ Closed Block Not Subsidized
  - ☐ Closed Block Subsidized

	HRP Membership	HRP Funding Requirement	Closed Block Membership	Closed Block Funding	Closed Block Premium Impact	Total Funding
Not Subsidized	900 to 1100	\$7M to \$13M	13K to 3K	none	34% to 170%	\$7M to \$13M
Subsidized	900 to 1000	\$7M to \$15M	13K to 5K	\$13.5M	15% to 20%	\$20M to \$27M

# Summary of Results

## Health Reform Impact

Health Reform	Average Premium Impact		Member Impact	Funding
Merged Market 1.10 GSA	IM -8%	SG +3%	1,350	none
Merged Market 1.20 GSA	IM -4%	SG +1%	800	none
Reinsurance Individual Market \$30M	IM -21%		4,500	\$30M
Reinsurance Individual Market \$15M	IM -11%		2,300	\$15M
Reinsurance Merged Market \$30M 1.10 GSA	IM -13%	SG -2%	2,900	\$30M
High Risk Pool Not Subsidized for Closed Block (CB)	IM OB -30%	IM CB +34% to +170%	3,500	\$7M to \$15M
High Risk Pool Subsidized for Closed Block (CB)	IM OB -30%	IM CB +15% to +20%	3,500	\$20M to \$27M

IM = Individual Market  
 SG = Small Group market  
 OB = Open Block  
 CB = Closed Block  
 GSA = Group Size Adjustment



# Summary of Results

## Range of Premium Impact

Health Reform	Premium Impact Range		
	Minimum	Maximum	Average
Merged Market 1.10 GSA SG Market	-12%	7%	3%
Merged Market 1.20 GSA SG Market	-8%	3%	1%
Reinsurance Merged Mkt \$30M 1.10 GSA SG Market	-17%	2%	-2%
High Risk Pool Not Subsidized for Closed Block (CB)	-60%	170%	-9%
High Risk Pool Subsidized for Closed Block (CB)	-60%	60%	-17%

IM = Individual Market  
 SG = Small Group market  
 OB = Open Block  
 CB = Closed Block  
 GSA = Group Size Adjustment

## Small Group Health Insurance Market Rate Restrictions, 2010

[Table](#)   [Map](#)   [Map & Table](#)

Rank By:

Region Name

	Type of Rating Restriction	Limits on Rating
United States	NA	NA
Alabama	Rate Bands	Yes
Alaska	Rate Bands	Yes
Arizona	Rate Bands	Yes
Arkansas	Rate Bands <sup>1</sup>	Yes
California	Rate Bands	Yes
Colorado	Adjusted Community Rating	Yes
Connecticut	Adjusted Community Rating	Yes
Delaware	Rate Bands	Yes
District of Columbia	No Rating Restrictions	No
Florida	Rate Bands	Yes
Georgia	Rate Bands	Yes
Hawaii	No Rating Restrictions	No
Idaho	Rate Bands	Yes
Illinois	Rate Bands	Yes
Indiana	Rate Bands	Yes
Iowa	Rate Bands	Yes
Kansas	Rate Bands	Yes
Kentucky	Rate Bands	Yes
Louisiana	Rate Bands <sup>4</sup>	Yes
Maine	Adjusted Community Rating	Yes
Maryland	Adjusted Community Rating	Yes
Massachusetts	Adjusted Community Rating	Yes
Michigan	Rate Bands <sup>2</sup>	Yes
Minnesota	Rate Bands	Yes
Mississippi	Rate Bands	Yes
Missouri	Rate Bands	Yes
Montana	Rate Bands	Yes
Nebraska	Rate Bands	Yes
Nevada	Rate Bands	Yes
New Hampshire	Rate Bands	Yes
New Jersey	Adjusted Community Rating	Yes
New Mexico	Rate Bands	Yes
New York	Pure Community Rating	Yes
North Carolina	Rate Bands	Yes
North Dakota	Rate Bands <sup>1</sup>	Yes
Ohio	Rate Bands	Yes
Oklahoma	Rate Bands	Yes
Oregon	Adjusted Community Rating	Yes
Pennsylvania	No Rating Restrictions <sup>3</sup>	No
Rhode Island	Adjusted Community Rating	Yes
South Carolina	Rate Bands	Yes
South Dakota	Rate Bands	Yes
Tennessee	Rate Bands <sup>4</sup>	Yes
Texas	Rate Bands	Yes
Utah	Rate Bands	Yes
Vermont	Adjusted Community Rating	Yes
Virginia	No Rating Restrictions <sup>7</sup>	No
Washington	Adjusted Community Rating	Yes
West Virginia	Rate Bands	Yes
Wisconsin	Rate Bands	Yes
Wyoming	Rate Bands	Yes

(show/hide notes)

Notes: The rules presented in this chart are only applicable small-group employer plans. Rules that apply to individuals are available at [Individual Market Guaranteed Issue](#)

**Sources:** Data as of January 2010. Data compiled through review of federal and state laws. For more detailed information on consumer protections in any state see Georgetown University's "Consumer Guides For Getting and Keeping Health Insurance" available at <http://www.healthinsuranceinfo.net/>. Data collection and analysis by researchers at the Health Policy Institute, Georgetown University.

**Definitions:** **Rate Rules:** In many states insurers are permitted to vary premiums for small group health insurance on, among other factors, the health status of the small employer group. A few states impose rating restrictions and prohibit rating based on health status. In some states, **pure community rating** is required, so premiums also cannot vary based on health status or any other factor. **Adjusted community rating** means premiums can not vary based on health status but may be adjusted based on other factors. Other states impose **health status rate bands** which limit the amount by which premiums can vary due to health status. Rating bands vary substantially across states; in some states, small group premiums could be surcharged by more than 100 percent for health status.

**Footnotes:**

1. Rate bands apply only to groups sized 2-25.
2. Rate bands apply only to groups sized 3-35.
3. BCBS non-profit hospital corporations and non-profit professional health service plans) and HMOs are permitted to set premiums using an adjusted community rating.
4. Rating restrictions apply only to groups sized 2-25.
5. BCBS and HMOs are permitted to set premiums using rate bands.
6. Rating restrictions apply only to groups sized 3-25.
7. Insurers are permitted to set premiums for standardized policies using rate bands.


**Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals), 2010**

Rank By:

Region Name

	Limits on Rating?	Types of Rating Restrictions?	Noteable Exceptions
United States	NA	NA	
Alabama	No	No	
Alaska	No	No	
Arizona	No	No	
Arkansas	No	No	
California	No	No	
Colorado	No	No	
Connecticut	No	No	
Delaware	No	No	
District of Columbia	No	No	
Florida	No	No	
Georgia	No	No	
Hawaii	No	No	
Idaho	Yes	Rate Bands	
Illinois	No	No	
Indiana	No	No	
Iowa	Yes	Rate Bands	
Kansas	No	No	
Kentucky	Yes	Rate Bands	
Louisiana	Yes	Rate Bands	
Maine	Yes	Adjusted Community Rating	
Maryland	No	No	
Massachusetts	Yes	Adjusted Community Rating	
Michigan	No	No	
Minnesota	Yes	Rate Bands	
Mississippi	No	No	
Missouri	No	No	
Montana	No	No	
Nebraska	No	No	
Nevada	Yes	Rate Bands	
New Hampshire	Yes	Rate Bands	
New Jersey	Yes	Adjusted Community Rating	Premiums for Basic and Essential plans are adjusted for age, gender, and geography.
New Mexico	Yes	Rate Bands	
New York	Yes	Pure Community Rating	
North Carolina	No	No	
North Dakota	Yes	Rate Bands	
Ohio	No	No	Premiums for guaranteed issued policies are capped at 2 times the standard rate for underwritten individual market policies.
Oklahoma	No	No	HMOs are required to community rate.
Oregon	Yes	Adjusted Community Rating	
Pennsylvania	No	No	
Rhode Island	No	No	
South Carolina	No	No	
South Dakota	Yes	Rate Bands	
Tennessee	No	No	
Texas	No	No	
Utah	Yes	Rate Bands	
Vermont	Yes	Adjusted Community Rating	
Virginia	No	No	
Washington	Yes	Adjusted Community Rating	

	Limits on Rating?	Types of Rating Restrictions?	Noteable Exceptions
United States	NA	NA	
West Virginia	No	No	
Wisconsin	No	No	
Wyoming	No	No	

[show](#) [hide](#) notes

**Notes:** This chart is not applicable to HIPAA eligible individuals. HIPAA eligible individuals may be subject to these rules if buying a non-HIPAA product. For rules that apply to HIPAA eligible individuals refer to [HIPAA Rules](#).

**Sources:** Data as of January 2010. Data compiled through review of federal and state laws. For more detailed information on consumer protections in any state see Georgetown University's "Consumer Guides For Getting and Keeping Health Insurance" available at <http://www.healthinsuranceinfo.net/>. Data collection and analysis by researchers at the Health Policy Institute, Georgetown University.

**Definitions:** **Rate Rules:** In many states, premiums for individual health insurance vary based on health status. A few states impose rating restrictions and prohibit rating based on health status in the individual market. In some states, **pure community rating** is required, so premiums also cannot vary by age or gender. **Adjusted community rating** means premiums can be adjusted for age or other factors. Other states impose **health status rate bands** which limit the amount by which premiums can vary due to health status.